Government of Western Australia
Department of Health

Admitted Subacute & Non-acute Care Data Collection

SANADC REFERENCE MANUAL 2014/2015



Inpatient Data Collections
Data Integrity Directorate
Resourcing and Performance Division

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Contents

Abbreviations

Abbreviation	Definition
ABF	Activity Based Funding
AIHW	Australian Institute of Health and Welfare
AMHOCN	Australian Mental Health Outcomes and Classification Network
AN-SNAP	Australian National Subacute and Non-acute Patient Classification
AROC	Australasian Rehabilitation Outcomes Centre
AHSRI	Australian Health Services Research Institute
DSS	Data Set Specification
FIM	Functional Independence Measure
GEM	Geriatric Evaluation and Management
HCARe	Health Care and Related Information System
HMDS	Hospital Morbidity Data System
HoNOS 65+	Health of the Nation Outcomes Scale 65+
IHPA	Independent Hospital Pricing Authority
NHDD	National Health Data Dictionary
NHRA	National Health Reform Agreement
NOCC	National Outcomes and Casemix Collection
PAS	Patient Administration System
PCOC	Palliative Care Outcomes Collaboration
PSOLIS	Psychiatric Services Online Information System
QoCR	Quality of Care Register
RUG-ADL	Resource Utilisation Group – Activities of Daily Living
SANADC	Subacute and Non-acute Care Data Collection
TOPAS	The Open Patient Administration System
UMRN	Unit Medical Record Number
URN	Unit Record Number
WA	Western Australia

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SECTION 1: ABOUT THE COLLECTION

Overview

The Subacute and Non-Acute Care Data Collection (SANADC) is a specialised repository of important clinical and non-clinical information about admitted patients receiving the following types of care:

- Rehabilitation
- Geriatric Evaluation and Management (GEM)
- Psychogeriatric Care
- Palliative Care
- Maintenance Care

The repository is specifically set up to collect detailed subacute and non-acute care clinical assessments that assist in measuring the quality and efficacy of inpatient subacute and non-acute programs. These clinical assessments play an integral role in allocation of an AN-SNAP class to individual subacute and non-acute records.

The SANADC receives data from a variety of sources. The majority of demographic, admission, discharge and morbidity information is sourced from the Hospital Morbidity Data System (HMDS). While subacute and non-acute specific information is sourced from specialised systems such as Quality of Care Register (QoCR) and Psychiatric Services Online Information System (PSOLIS).

The Western Australian Department of Health are mandated under the National Health Reform Agreement (NHRA) to provide the Independent Hospital Pricing Authority (IHPA) with a quarterly data submission containing all public admitted subacute and non-acute activity. IHPA then utilise the submissions to classify all activity into Australian National Subacute and Non-acute Patient (AN-SNAP) Classification (Version 3) for the purpose of Activity Based Funding (ABF) initiatives.

Purpose of the Collection

The SANADC provides WA Department of Health and IHPA with the necessary information for planning, allocating and evaluating subacute and non-acute care programs within Western Australia, in turn, IHPA determine the level of state funding. Other key purposes of the collection include provision of information for:

- Monitoring and assessing subacute and non-acute health service utilisation
- Epidemiological and medical research
- Data linkage

Definition of Subacute and Non-acute Care

Subacute care is defined as specialised multidisciplinary care in which the primary need for care is optimisation of the patient's functioning and quality of life. A person's functioning may relate to their whole body or a body part, the whole person, or the whole person in a social context and to the impairment of a body function or structure, activity limitation and/or participation restriction.

Subacute care consists of the following care types:

- Rehabilitation care
- Palliative Care
- Geriatric Evaluation and Management (GEM)
- Psychogeriatric care.

Non-acute care comprises of the following care type:

- Maintenance care

Scope of the Collection

The SANADC receives clinical data from both public and private sector health services. As the Collection is still in development a number of exclusions are applied to ensure compliance with mandatory reporting requirements, however additional data is still stored and monitored for future relevance.

The subacute and non-acute activity data that is currently in-scope for collection include:

- Admitted sameday and overnight episodes in designated subacute and non-acute care units, programs and hospitals
- Admitted public patients receiving care in private hospitals on a contract basis in designated subacute and non-acute care units, programs and hospitals
- Admitted patients receiving subacute or non-acute care in the home.

The subacute and non-acute activity data that is currently out-of-scope for collection includes:

- Admitted subacute and non-acute episodes in non-designated units, programs or hospitals
- Hospitals operated by Australian Defence Force, correctional authorities and Australian external territories.

SANADC does receive some clinical assessment information for admitted subacute and non-acute episodes in non-designated units, programs and hospitals as they do provide a significant portion of subacute and non-acute care. As the designation status is a state-based determination, this activity data is quarantined and monitored on an ongoing basis to identify possible qualification as a designated subacute/non-acute service in the future (and therefore becomes in-scope for collection and reporting).

Unit of Measurements

There are various units of measurement available to users of SANADC data.

Admitted data set:

- Episode of care: An episode of care starts with a formal admission to hospital and ends with a formal discharge or separation from hospital.
- Palliative Care: Phase of Care and Resource Utilisation Groups – Activities of Daily Living (RUG-ADL) clinical assessment.
- Psychogeriatric: HoNOS 65+ clinical assessment.
- Rehabilitation: Functional Independence Measure(s) clinical assessment.
- GEM: Functional Independence Measure(s) clinical assessment.
- Maintenance: RUG-ADL clinical assessment.

Subacute Care Data Collection Team

The SANADC is maintained by the Subacute Care Data Collection Team (SACDT) within the Resourcing and Performance Division.

To ensure that SANADC remains valuable and relevant, the Team is responsible for:

- Providing advice and support to data collectors at health service level to ensure complete and accurate reporting
- Enforcing data quality and providing data quality education
- Responding to regular and ad hoc data requests
- Supporting data users internal and external to WA Health
- Developing analytical tools
- Maintaining metadata.

SANADC Reference Manual

This Manual provides direction and guidelines for hospitals regarding the submission of data and the definitions of required data elements.

The appendices in the SANADC Reference Manual include further information on data values for certain data elements such as Establishment lists and Impairment Types.

SECTION 2: CONTACTS AND KEY LINKS

Contact Details

Subacute Care Data Collection Team

Manager, Subacute & Non-acute Data Collection	Ph: (08) 9222 0266
Data submission	Ph: (08) 9222 2497 Email: sana.data@health.wa.gov.au
Data quality queries	Ph: (08) 9222 0266 Ph: (08) 9222 2497 Email: sana.data@health.wa.gov.au
Data extracts	Ph: (08) 9222 2497
Ad hoc data requests	Ph: (08) 9222 2497

Health Reform Division

Senior Policy Officer	Ph: (08) 9222 4402 Email: activity@health.wa.gov.au

Key Websites

State

WA Health
http://www.health.wa.gov.au

HMDS Reference Manual
http://www.health.wa.gov.au/healthdata/resources/hmds.cfm

Activity Based Funding (Western Australia)
http://www.health.wa.gov.au/activity/home/

National

Australian Health Services Research Institute (AHSRI)
http://ahsri.uow.edu.au

Australian Institute of Health and Welfare
METeOR (Metadata Online Repository)
National Health Data Dictionary (NHDD)
Australian Hospital Statistics
These and other publications/resources may be accessed from:
Web page: http://www.aihw.gov.au

Australian Mental Health Outcomes and Classification Network
Web page: http://amhocn.org/
E-mail: info@amhocn.org
Telephone: (02) 9840 3833
Facsimile: (02) 9840 3838

Australian Rehabilitation Outcomes Centre (AROC)
Web page: http://ahsri.uow.edu.au/aroc/index.html
E-mail: aroc@uow.edu.au
Telephone: (02) 4221 4411
Facsimile: (02) 4221 4679

Independent Hospital Pricing Authority
Information on Activity Based Funding may be obtained from:
Web page: http://www.ihpa.gov.au
E-mail: enquiries.ihpa@ihpa.gov.au
Telephone: (02) 8215 1100
Facsimile: (02) 8215 1111

METeOR
Admitted sub-acute and non-acute hospital care data set specification
http://meteor.aihw.gov.au/content/index.phtml/itemId/496358

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SECTION 3: DATA COLLECTION REQUIREMENTS

3.1 Care Type Specific Clinical Assessments

For the majority of patients receiving subacute and non-acute care, the demographic, admission, discharge and morbidity information is captured in hospital Patient Administration Systems (PAS) and submitted to Department of Health via the HMDS. However, for AN-SNAP classification and subsequent funding, sites are required to submit additional data items for each episode of subacute or non-acute care. As per the table below, the number of additional data items required depends on the Care Type.

	FIM Scores	Impairment Code	HoNOS 65+ Scores	RUG-ADL(s)	Phase(s) of Care
Rehabilitation	✓	✓			
Geriatric Evaluation & Management	✓				
Psychogeriatric			✓		
Palliative Care				✓	✓
Maintenance Care				✓	

All data items are to be collected on admission**.**

3.1.1 Functional Independence Measure Instrument

The Functional Independence Measure (FIM) instrument is a clinical assessment tool applied to patients receiving Rehabilitation and GEM care to provide a basic indicator of disability severity. The functional ability of these patients can change during the care process and therefore the FIM™ instrument is useful in measuring the level of change and effectiveness of care.

The FIM™ instrument consists of 18 items that are divided into two major groups:

Motor

- Eating
- Grooming
- Bathing
- Dressing, upper body
- Dressing, lower body
- Toileting
- Bladder management
- Bowel management
- Transfers – bed/chair/wheelchair
- Transfers – toilet
- Transfers – bath/shower
- Locomotion
- Stairs

Cognitive

- Comprehension
- Expression
- Social interaction
- Problem solving

- Memory

Each item of functional ability is assessed against a seven point ordinal scale, where the higher the score for an item, the more independently the patient is able to perform the tasks assessed by that item. The seven point ordinal scale includes:

1 – Total assistance with helper
2 – Maximal assistance with helper
3 – Moderate assistance with helper
4 – Minimal assistance with helper
5 – Supervision or setup with helper
6 – Modified independence with helper
7 – Complete independence

The total score for the FIM instrument (the sum of the motor and cognition subscale scores) will be a value between 18 and 126. The total score for FIM™ motor subscale (the sum of the individual motor subscale items) will be a value between 13 and 91. The total score for the FIM cognition subscale (the sub of the individual cognition subscale items) will be a value between 5 and 35.

For the purposes of reporting to SANADC, FIM™ scores must be collected within 72 hours of patient admission.

More information on the FIM™ instrument can be found via the Australian Health Services Research Institute (AHSRI) website: http://ahsri.uow.edu.au/aroc/whatisfim/index.html.

3.1.1.1 FIM Training and Credentialing

The Australian Rehabilitation Outcomes Collaboration (AROC), under the auspices of the AHSRI, holds the license for the use of the FIM™ instrument. The AROC are the national certification and training body for the FIM™ instrument. The AROC requires clinicians to be formally trained and credentialed in the application of the FIM instrument and undergo credentialing exams every two years to ensure knowledge and skills are relevant and up-to-date.

Training workshops are administered through the AHSRI. For more information on FIM™ instrument training and credentialing, please refer to the AHSRI website:
http://ahsri.uow.edu.au/aroc/training/index.html#offerred.

3.1.2 Impairment Type(s)

The Impairment Type is a clinical data item representing the primary reason a patient is undergoing Rehabilitation. It is applicable to patients receiving Rehabilitation or GEM care only.

The list of Impairment Types are developed and administered by the AROC. The code listing contains the following high level of Impairment Types:

- Stroke
- Brain dysfunction
- Neurological conditions
- Spinal cord dysfunction
- Amputation of limb
- Arthritis
- Pain syndromes
- Orthopaedic conditions

- Cardiac
- Pulmonary
- Burns
- Congenital deformities
- Other disabling impairments
- Major multiple trauma
- Developmental disabilities
- Re-conditioning/restorative

Underneath each high level impairment type are a subset of codes providing more specific detail on the type of impairment. For example:

- Stroke
    - Left body involvement (right brain)
    - Right body involvement (left brain)
    - Bilateral involvement
    - No paresis
- Other stroke

For the purposes of reporting to SANADC, the Impairment Type is collected on patient admission.

More information on the FIM™ instrument can be found via the AHSRI website: http://ahsri.uow.edu.au/aroc.

3.1.3 Health of the Nation Outcome Scale 65+

The Health of the National Outcome Scale 65+ (HoNOS 65+) is a clinical assessment tool that is a part the suite National Outcomes and Casemix Collection (NOCC) measures administered by the Australian Mental Health Outcomes and Classification Network (AMHOCN). HoNOS 65+ consists of 12 scales used by clinicians before and after interventions to assess a range of psychiatric symptoms and psychosocial functioning in older adult patients receiving Psychogeriatric care.

The 12 scales include:

- Behavioural disturbance
- Non-accidental self injury
- Problem drinking or drug use
- Cognitive problems
- Problems related to physical illness or disability
- Problems associated with hallucinations and delusions
- Problems associated with depressive symptoms
- Other mental and behavioural problems
- Problems with social or supportive relationships
- Problems with activities of daily living
- Overall problems with living conditions
- Problems with work and leisure activities and the quality of the day time environment.

Together, the scales rate various aspects of mental and social health, each on a scale of 0 to 4. A HoNOS 65+ total score (the sum of each individual scale item) will be a value between 0 and 48.

For the purposes of reporting to SANADC, only the first set of HoNOS 65+ scores performed during the admission are required.

3.1.4 Resource Utilisation Groups – Activities of Daily Living

The Resource Utilisation Groups - Activities of Daily Living (RUG-ADL) scale measures the level of functional dependence of a patient for four activities of daily living. RUG-ADLs provide an indication of what a person actually does.

RUG-ADL measures the motor function of a patient for the following four activities of daily living (ADL):

- Bed mobility
- Toileting
- Transfers
- Eating.

RUG-ADL scores are only required for patients receiving Palliative Care or Maintenance Care. The total RUG-ADL score (the sum of the individual scale items) will be a value between 4 and 18. For the purposes of reporting to SANADC, only the first set of RUG-ADL scores performed during the admission are required.

3.1.5 Phase(s) of Care

Phase of Care information is required for palliative care episodes only and is used to flag clinically meaningful changes in a palliative care patient's health status during a palliative episode.

Phase of Care information consists of the following key data items:

- Palliative Care Phase Start Date
- Palliative Care Phase End Date
- Palliative Care Phase Type (Stable, Unstable, Deteriorating, Terminal, Unknown)

During a single episode of care, a palliative patient can change clinical phases many times as palliative care phases are not sequential. A patient can move back and forth between Phase Types.

SANADC has provision for the capture of the first 11 Phases of Care. Twelve or more Phases of Care do not need to be reported to SANADC.

The Palliative Care Phase Type should reflect the Phase Type the patient was at the commencement of the Phase, not the end.

Palliative care patients are also required to undergo RUG-ADL assessments performed at the start of each Phase of Care.

3.2 Rehabilitation Care

3.2.1 Definition

IHPA (2014a) defines Rehabilitation in the context of hospital services as:

Care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with an impairment, activity limitation or participation restriction due to a health condition. The patient will be capable of actively participating.

Rehabilitation care is always:

- *Delivered under the management of or informed by a clinician with specialised expertise in rehabilitation, and*
- *Evidenced by an individualised multidisciplinary management plan which is documented in the patient's medical record. The plan must include negotiated goals within specified time frames and formal assessment of functional ability.*

3.2.2 Data Collection Requirements

For Rehabilitation Care episodes, the following subacute care data items must be collected:

- Account/Admission Number
- Client Identifier
- Admission Date
- Separation Date
- Establishment Code
- Assessment Date
- Admission for Assessment Only
- FIM Score – Eating
- FIM Score – Grooming
- FIM Score – Bathing
- FIM Score – Dressing, upper body
- FIM Score – Dressing, lower body
- FIM Score – Toileting
- FIM Score – Bladder management
- FIM Score – Bowel management
- FIM Score – Transfers – bed/chair/wheelchair
- FIM Score – Transfers – toilet
- FIM Score – Transfers – bath/shower
- FIM Score – Locomotion
- FIM Score – Stairs
- FIM Score – Comprehension
- FIM Score – Expression
- FIM Score – Social interaction
- FIM Score – Problem solving
- FIM Score – Memory
- Impairment Type

Data for the above data items is to be entered in the Quality of Care Register (QoCR). This information is extracted weekly from QoCR by SANADC.

3.3 Geriatric Evaluation and Management

3.3.1 Definition

IHPA (2014b) defines Geriatric Evaluation and Management (GEM) in the context of hospital services as:

Care in which the primary clinical purpose or treatment goal is improvement in the functioning of a patient with multi-dimensional needs, associated with age related medical conditions. Some examples of conditions in GEM care patients include a tendency to fall, incontinence, reduced mobility and cognitive impairment. The patient may also have complex psychosocial problems.

GEM care is always:

- *Delivered under the management of or informed by a clinician with specialised expertise in GEM care, and*
- *Evidenced by an individualised multidisciplinary management plan which is documented in the patient's medical record. The plan must cover the physical, psychological, emotional and social needs of the patient, as well as include negotiated goals within indicative time frames and formal assessment of functional ability.*

It includes care provided:

- In a geriatric evaluation and management unit
- In a designated geriatric evaluation and management program
- Under the principal clinical management of a geriatric evaluation and management physician
- In the opinion of the treating doctor, when the principal clinical intent of care is geriatric evaluation and management.

GEM care is generally applicable to older patients however, younger adults with clinical conditions generally associated with old age can also be classified under this care type.

3.3.2 Data Collection Requirements

For GEM Care episodes, the following subacute care data items must be collected:

- Account/Admission Number
- Client Identifier
- Admission Date
- Separation Date
- Establishment Code
- Assessment Date
- Admission for Assessment Only
- FIM Score – Eating
- FIM Score – Grooming
- FIM Score – Bathing
- FIM Score – Dressing, upper body
- FIM Score – Dressing, lower body
- FIM Score – Toileting
- FIM Score – Bladder management
- FIM Score – Bowel management
- FIM Score – Transfers – bed/chair/wheelchair
- FIM Score – Transfers – toilet
- FIM Score – Transfers – bath/shower
- FIM Score – Locomotion
- FIM Score – Stairs
- FIM Score – Comprehension
- FIM Score – Expression
- FIM Score – Social interaction
- FIM Score – Problem solving
- FIM Score – Memory
- Impairment Type

Data for the above data items is to be entered in the Quality of Care Register (QoCR). This information is extracted weekly from QoCR by SANADC.

3.4 Psychogeriatric Care

3.4.1 Definition

IHPA (2014c) defines Psychogeriatric Care in the context of hospital services as:

Care in which the primary clinical purpose or treatment goal is improvement in the functional status, behaviour and/or quality of life for an older patient with significant psychiatric or behavioural disturbance. The disturbance is caused by mental illness, age related organic brain impairment or a physical condition.

Psychogeriatric care is always:

- *Delivered under the management of or informed by a clinician with specialised expertise in psychogeriatric care, and*
- *Evidenced by an individualised multidisciplinary management plan which is documented in the patient's medical record. The plan must cover the physical, psychological, emotional and social needs of the patient, as well as include the negotiated goals within indicative time frames and formal assessment of functional ability.*

It includes care provided:

- In a Psychogeriatric care unit
- In a designated Psychogeriatric care program
- Under the principal clinical management of a Psychogeriatric physician
- In the opinion of the treating doctor, when the principal clinical intent of care is Psychogeriatric care.

3.4.2 Data Collection Requirements

For Psychogeriatric Care episodes, the following subacute care data items must be collected:

- Account/Admission Number
- Client Identifier
- Admission Date
- Separation Date
- Establishment Code
- Assessment Date
- Admission for Assessment Only
- HoNOS 65+ Score – Behavioural disturbance
- HoNOS 65+ Score – Non-accidental self injury
- HoNOS 65+ Score – Problem drinking or drug use
- HoNOS 65+ Score – Cognitive problems
- HoNOS 65+ Score – Problems related to physical illness or disability
- HoNOS 65+ Score – Problems associated with hallucinations and delusions
- HoNOS 65+ Score – Problems associated with depressive symptoms
- HoNOS 65+ Score – Other mental and behavioural problems
- HoNOS 65+ Score – Problems with social or supportive relationships
- HoNOS 65+ Score – Problems with activities of daily living
- HoNOS 65+ Score – Overall problems with living conditions
- HoNOS 65+ Score – Problems with work and leisure activities and quality of day time environment

Data for the above data items is to be entered in the Psychiatric Services Online Information System (PSOLIS). This information is extracted monthly from PSOLIS by SANADC.

3.5 Palliative Care

3.5.1 Definition

IHPA (2014d) defines Palliative Care in the context of hospital services as:

Care in which the primary clinical purpose or treatment goal is optimisation of the quality of life of a patient with an active and advanced life-limiting illness. The patient will have complex physical, psychosocial and/or spiritual needs.

Palliative care is always:

- *Delivered under the management of or informed by a clinician with specialised expertise in palliative care, and*
- *Evidenced by an individualised multidisciplinary assessment and management plan which is documented in the patient's medical record. The plan must cover the physical, psychological, emotional, social and spiritual needs of the patient, as well as include negotiated goals.*

It includes care provided:

- In a palliative care unit
- In a designated palliative care program
- Under the principal clinical management of a palliative care physician or, in the opinion of the treating doctor, when the principal clinical intent of care is palliation.

3.5.2 Data Collection Requirements

For Palliative Care episodes, the following subacute care data items must be collected:

- Account/Admission Number
- Client Identifier
- Admission Date
- Separation Date
- Establishment Code
- Assessment Date
- Admission for Assessment Only
- Palliative Care Phase Start Date(s)
- Palliative Care Phase End Date(s)
- Palliative Care Phase Type(s)
- RUG-ADL score(s) – Bed mobility
- RUG-ADL score(s) – Toileting
- RUG-ADL score(s) – Transfers
- RUG-ADL score(s) – Eating

3.6 Maintenance Care

3.6.1 Definition

Maintenance care is non-acute care in which the clinical intent or treatment goal is prevention of deterioration in the functional and current health status of a patient with a disability or severe level of functional impairment. Following assessment or treatment the patient does not require further complex assessment or stabilisation, and requires care over an indefinite period. This care includes that provided to a patient who would normally receive care in another setting (e.g. at home, or in a residential aged care service, by a relative or carer) that is unavailable in the short term.

Types of maintenance care include:

- Care and support of a person in an inpatient setting whilst the patient is awaiting transfer to residential care or alternate support services or where there are factors in the home environment (physical, social, psychological) which make discharge to home inappropriate for the person in the short term
- Psychogeriatric patients receiving respite or non-acute care
- Patients in receipt of care where the sole reason for admitting the person to hospital is that the care that is usually provided in another environment (e.g. at home, in a nursing home, by a relative or with a guardian) is unavailable in the short term (respite care)
- Care and support of a person with a functional impairment for whom there is no multi-disciplinary program aimed at improvement of functional capacity
- Care Awaiting Placement: Where a patient who has been assessed as requiring more intensive day-to-day care than that which can be provided in their home environment and are awaiting placement in a Nursing Home or Hostel but whose length of stay is not exceeding 35 days.

3.6.2 Data Collection Requirements

For maintenance care episodes the following non-acute care data items must be collected:

- Account/Admission Number
- Client Identifier
- Admission Date
- Separation Date
- Establishment Code
- Assessment Date
- Admission for Assessment Only
- Type of Maintenance
- RUG-ADL score(s) – Bed mobility
- RUG-ADL score(s) – Toileting
- RUG-ADL score(s) – Transfers
- RUG-ADL score(s) – Eating

SECTION 4: DATA SUBMISSION REQUIREMENTS

4.1 Data Source Systems

4.1.1 Hospital Morbidity Data System

To minimise duplicate reporting, the SANADC sources relevant demographic, admission, discharge and morbidity information directly from the Hospital Morbidity Data System (HMDS) after it has been through the HMDS data quality process.

The HMDS is one of the largest data collections managed by the Department of Health. This repository is comprised of more than 21,000,000 electronic inpatient records dating back to 1970. Under Part IIIC of the *Hospital and Health Services Act 1927*, the Department of Health mandates all public and private hospitals to submit complete, accurate and timely admitted activity data to the HMDS in accordance with agreed data management protocols.

For further information on the HMDS, please refer to the following web address: http://www.health.wa.gov.au/healthdata/resources/hmds.cfm.

4.1.2 Quality of Care Register

QoCR is a secondary patient administration system that enables hospitals with public designated rehabilitation and GEM wards to enter specific clinical information as required by the Australasian Research Outcomes Centre (AROC). In turn, the data captured in QoCR is used to meet national AROC reporting requirements and subsequent national benchmarking and clinical improvement purposes.

For all GEM and Rehabilitation episodes, the Quality of Care Register (QoCR) captures FIM and Impairment Type information. This information is directly entered into QoCR by the reporting health services. In turn SANADC receives a weekly extract from QoCR of FIM and Impairment data. Using the hospital identifier and account number, the FIM scores and Impairment Type are linked to the HMDS inpatient record to create a complete subacute record.

QoCR is only available in certain hospitals with designated rehabilitation and GEM wards. Sites equipped to enter GEM and Rehabilitation data in QoCR include:

Public	Private
Albany Hospital	Mercy Hospital
Armadale/Kelmscott District Memorial Hospital	Peel Health Campus
Bentley Hospital	
Bunbury Hospital	
Fiona Stanley Hospital	
Fremantle Hospital & Health Service	
Kalamunda District Community Hospital	
Osborne Park Hospital	
Sir Charles Gairdner Hospital	
Swan District Hospital	
Royal Perth Hospital	

4.1.3 Psychiatric Services Online Information System

The PSOLIS is a dedicated mental health patient administration system designed to collect demographic, admission, discharge, service event, morbidity and treatment information on patients/clients receiving care in public mental health services.

For all Psychogeriatric episodes, the Psychiatric Services Online Information System (PSOLIS) captures HoNOS 65+ information. This information is directly entered into PSOLIS by the reporting health services. In turn SANADC, receives an automated weekly extract from PSOLIS containing HoNOS 65+ information. Using the hospital identifier and account number, the HoNOS 65+ scores are linked to the HMDS inpatient record to create a complete subacute record.

PSOLIS is only available in public mental health services, therefore no HoNOS 65+ is sourced from any private hospitals at this time.

4.1.4 SANADC Data Collection E-Form

SANADC has developed the SANADC Data Collection E-Form which is available to sites that do not have a more automated method of collecting and reporting subacute/non-acute data.

The SANADC Data Collection E-Form is an electronic data capture tool written in Microsoft Visual Basic and available for use via Microsoft Excel. This E-Form allows users to enter and save Care Type specific information and on completion, generate a data extract as a fixed width text file that can be emailed directly to SANADC.

Please note that SANADC strongly encourages reporting health services to develop sophisticated information systems that support efficient and accurate data entry and ensures data accessibility. The SANADC Data Collection E-Form is not a sophisticated information system and is purely available as an interim mechanism for reporting data to SANADC until a site can transition to a standardised and comprehensive information system.

If you need to utilise the SANADC Data Collection E-Form please contact the SANADC Team. Contact details can be found under Section 2: Contacts and Key Links.

4.1.5 Other Source Systems

4.1.5.1 Palliative Care

At present, there is no enterprise wide information system dedicated to capturing Palliative Care information. Some sites have developed in-house databases to capture information for Palliative Care Outcomes Collaboration (PCOC) reporting. However these databases do not provide the necessary linking the variables required to match the Palliative Care information to the HMDS record.

Efforts are underway to develop webPAS, the new statewide patient administration system that is gradually being introduced, to include data collection functionality for palliative care. Also, the Palliative Care Network continues to pursue the development and implementation of a statewide palliative care information system that could provide a single source solution for capturing palliative care in both the public and private sector.

4.1.5.2 Maintenance Care

At present, there is no enterprise wide information system dedicated to capturing Maintenance Care information. Efforts are underway to develop webPAS, the new statewide patient administration system that is gradually being introduced, to include data collection functionality for Maintenance Care.

4.2 Guidelines for Submission of Data

4.2.1 Methods of Submission

Data can only be submitted to SANADC in an electronic format. SANADC does not have the resourcing to support hardcopy submissions of data.

4.2.1.1 QoCR Supporting Sites

Subacute/non-acute services that utilise QoCR are not required to 'submit' data to the SANADC. All necessary data is automatically extracted and transferred to SANADC on a weekly basis without technical input from the front end user.

4.2.1.2 Non-QoCR Supporting Sites

Subacute/non-acute services that utilise an alternate or in-house information system for collection of data, are required to submit data in an electronic format that is compliant with the Subcute/Non-acute Care ABF Technical Specifications for Submission of Data. Please refer to *Appendix 4 – Subacute/Non-acute Care ABF Technical Specifications for Submission of Data.*

The format type for submission is a flat, fixed width text file. Any alternative formats should be discussed and agreed upon with the SANADC Team prior to submission.

4.2.2 Due Dates for Submission

4.2.2.1 QoCR Supporting Sites

Data submission due dates are not applicable for QoCR supporting sites. Data can be sourced and transferred weekly to SANADC without technical input from the front end user.

4.2.2.2 Non-QoCR Supporting Sites

Data for the preceding month must be submitted to SANADC by the 7th working day of the month. For example, all completed data for July must be submitted to SANADC by the 7th August.

4.2.3 Penalties for Non-Compliance

Under the terms of the IHPA's proposed funding arrangements from 1 July 2015, any subacute/non-acute records that are not submitted to the SANADC for AN-SNAP grouping or fail to group because they are in error, will not receive Commonwealth funding.

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SECTION 5: DATA QUALITY AND ERROR CORRECTION

5.1 What is Data Quality?

Data Quality occurs when information is:

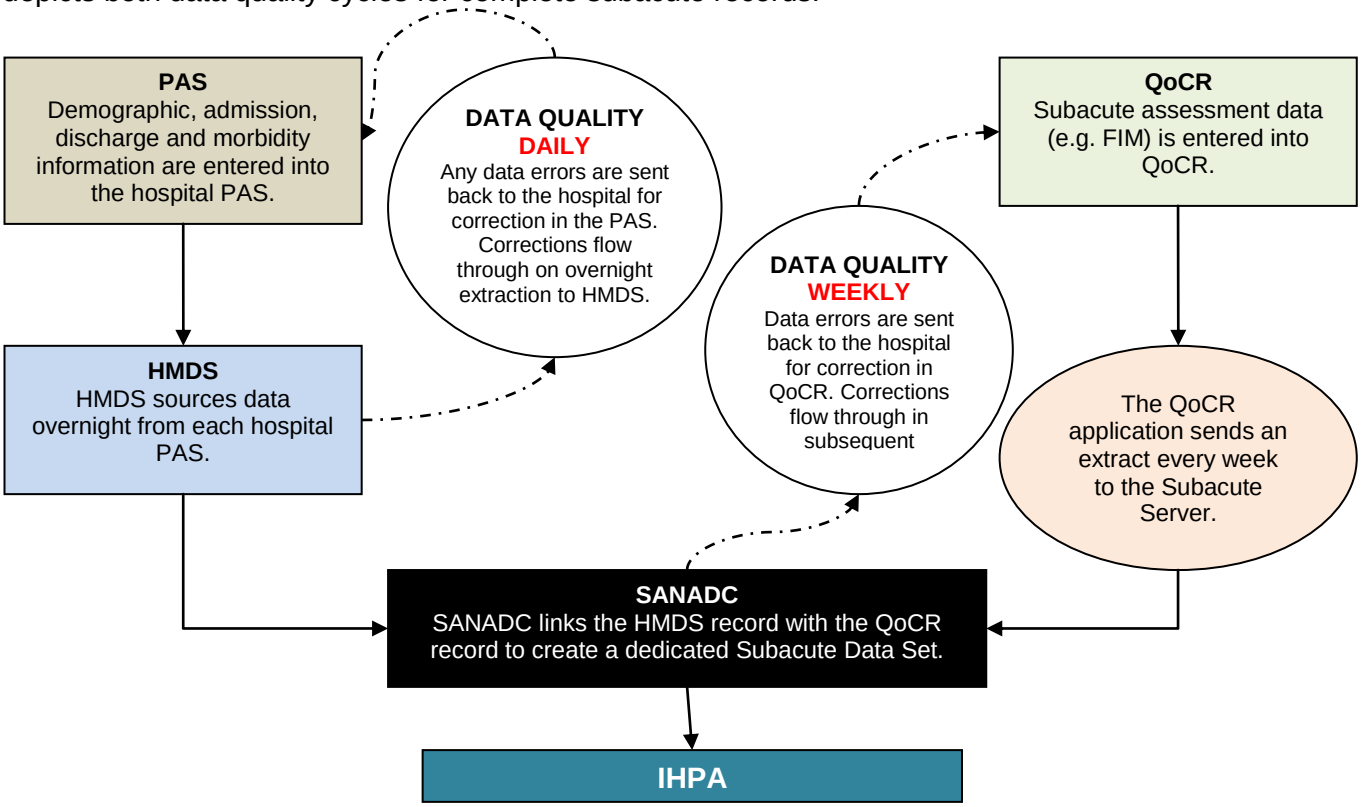
- accurate and precise as much as possible
- captured in a consistent format
- conforms to standardised business rules
- relevant and necessary
- available
- timely
- transmitted and stored securely.

Data quality is important in any data collection, however it is particularly important within the SANADC as even the slightest error or omission in a single data item can render the record invalid for reporting and funding under the AN-SNAP Classification. Effectively, if a record is to pass through the SANADC for reporting and funding it must be perfect!

5.2 Data Quality Cycle

Although data submission methods and sources may vary from site to site, the Data Quality Cycle is the same for all reporting services.

There are two data cleansing processes that occur for data submitted to SANADC. The first process concerns data that is submitted to the HMDS. This data relates to demographic, admission, discharge and morbidity information. This data undergoes the HMDS Data Quality Cycle. The second process concerns the subacute clinical assessment data items (i.e. FIM, Impairment Type, HoNOS 65+, Phase of Care and RUG-ADL). This data undergoes the SANADC Data Quality Cycle. The following flow diagram depicts both data quality cycles for complete subacute records:



5.2 Data Quality Edits

Data quality errors that are sent back the responsible site are called Data Quality Edits. Edits consist of a set of rules or parameters for what makes a record wrong, invalid or inconsistent. For example, the rules of a particular edit might say that if the date entered in the Assessment Date field is before the Admission Date then the record is in error due to inconsistency between dates.

Data Quality Edits each have an Edit Code or Edit Message that helps the user determine what is wrong with the record. In some cases, the user may need to refer to the precise Edit Logic to isolate the fields that could be causing the edit to trigger.

For the HMDS Data Quality Cycle, there are more than 440 data quality edits screening the demographic, admission, discharge and morbidity information of a record. For the SANADC Data Quality Cycle, there are 43 data quality edits that exclusively screen the integrity of subacute clinical assessment data.

Please refer to *Appendix 6: SANADC Data Quality Edits* for detailed descriptions of all data quality edits and associated edit logic. This listing is useful in addressing data quality errors listed in Data Quality Edit Reports (see 5.4 Data Quality Edit Reports).

5.3 Types of Data Quality Edits

There are seven groups or classes of Data Quality Edits for subacute data which are focused primarily on the Care Type specific clinical assessment tool:

- FIM (error series 1XXX)
- Impairment Type (error series 2XXX)
- HoNOS 65+ (error series 3XXX)
- RUG-ADL (error series 4XXX)
- Phase of Care (error series 5XXX)
- Maintenance (errors series 6XXX)
- Assessment/Other (error series 9XXX).

Please note that these classes do not include the Data Quality Edits performed on the data items sourced from the HMDS record. As per the *5.2 Data Quality Cycle*, data sourced from HMDS has already undergone data quality validations and correction by the time it reaches the SANADC.

If a subacute or non-acute record triggers a data quality edit from any error class, it should be treated as a critical error and addressed as a matter of priority. A record in critical error will not be reported as the errors within the record prohibit successful grouping to a valid AN-SNAP classification. It is important to note that where a record cannot be grouped to AN-SNAP, the health service may not be financially reimbursed or may be reimbursed at a reduced cost weight under the Australian Refined Diagnosis Related Group classification.

From 1 July 2015, any subacute or non-acute episode that cannot be grouped to AN-SNAP will not be funded. Therefore, it is imperative that all subacute and non-acute data is complete, accurate and timely.

5.4 Data Quality Edit Reports

5.3.1 Definition

Data Quality Edit Reports are a Microsoft Excel spreadsheet that provides a record level listing of all year-to-date (YTD) errors in reported subacute/non-acute information.

SANADC generates these reports weekly and sends them via e-mail to a subacute representative at each hospital with one or more designated subacute wards or programs.

The purpose of these reports is to provide hospitals with a listing of errors relating to record level subacute data that has been submitted to SANADC and provide sufficient reference information to enable subsequent correction.

5.3.2 Report Structure

A standard Data Quality Edit Report will consist of the following tabs:

- Summary Report: This provides a two table overview of the number of errors by care type and number of errors by Edit.
- Care Type Reports:
    - GEM care: This provides a record level listing of all the GEM records that have triggered one or more errors. This tab will only exist if there are GEM records in error.
    - Rehabilitation care: This provides a record level listing of all the Rehabilitation care records that have triggered one or more errors. This tab will only exist if there are Rehabilitation care records in error.
    - Maintenance care: This provides a record level listing of all the Maintenance care records that have triggered one or more errors. This tab will only exist if there are Maintenance records in error.
    - Palliative care: This provides a record level listing of all the Palliative care records that have triggered one or more errors. This tab will only exist if there are Palliative care records in error.

The Summary Report tab will appear on all Data Quality Edit Reports. However, a tab by care type (GEM, Rehabilitation care etc) will only exist if there are records in error for that care type. Therefore, the fewer tabs appearing in a report means greater data quality.

A single record can trigger one or more errors, so where a record appears across multiple lines this indicates that there are multiple errors attached to the one record. Where this occurs refer to the Edit code and message and address accordingly.

5.3.3 Understanding Data Quality Edit Reports

5.3.3.1 Summary Report

This report is provided for reference purposes and to facilitate any trending you may wish to perform over time.

5.3.3.2 Care Type Report

The format of a Care Type Report is the same for all subacute care types. A Care Type report will consist of the following fields:

Field	Field Description
Hospital Number	The unique identifier for the hospital
Client Identifier	The unique identifier assigned by the hospital (e.g. UMRN, URN etc) for the patient.
Event Identifier (ID)	The unique event identifier assigned by the HMDS to this episode. Generally not useful for hospital purposes but aids SANADC in efficiently identifying a unique episode should a hospital have any queries.
Account Number	The unique account identifier assigned by hospital to identify the episode.
Admission Date	The date upon which the episode commenced.
Separation Date	The date upon which the episode ended.
Assessment Date	The date upon which the relevant clinical assessment (FIM, HoNOS 65+, RUG-ADL, Phase of Care etc) was performed.
Care Type	The type of care the patient received during their episode of care.
Ward	The ward the patient was separated from upon completion of their episode of care.
Edit Code	The unique code used to identify a type of edit.
Edit Description	The description of the edit or error attached to the record. The edit description is a standardised message. Although descriptive, it may not provide all the information needed to identify the particular fields in error. The reviewer may need to refer to the *Appendix 6: SANADC Data Quality Edits* to reference the specific business rules and fields responsible for triggering the edit.
Last Amended HE Number	The unique employee or user number of the last person to edit the record. It must not assumed that the last HE number attached to the record is the person responsible for making the error. Infact, if the record is corrected this field will be updated to reflect the person who corrected it.
Last Amended Date	The date the record was last amended. Please note that amended does not mean corrected, it simply means the last date upon which any changes (right or wrong) were made to the record.
Comments	This is a free text field available to both hospital and SANADC team to provide any specific information or explanation in relation to a particular error.

5.3.4 How to address a Data Quality Edit Report

Once you have a good understanding of the content of the Data Quality Edit Report then you can take steps towards referencing and addressing data quality edits.

The following is a suggested protocol for addressing errors listed in your Data Quality Edit Report:

1. Identify the Edit Code and Edit Description for a specific record in the Data Quality Edit Report.
2. Refer to the Edit Logic (as specified in *Appendix 6: SANADC Data Quality Edits*) and make a note of the specific fields that are referenced in the Edit Logic.
3. Look up record in the information system (e.g. QoCR).
4. Identify fields in the information system that are referenced in the Edit Logic.
5. Update or correct relevant fields.
6. Document any changes made or comments in the Comments field of the Data Quality Edit Report.
7. Once all edits have been reviewed and/or commented, send the Data Quality Edit Report back to SANADC.

All errors within a Data Quality Edit Report should be addressed in a timely manner (preferably within the week). This is not only to ensure efficient and accurate reporting of subacute numbers but to minimise site level administrative burdens associated with record retrieval and follow-up.

5.3.5 Frequency of Data Quality Edit Reporting

Data Quality Edit Reports are generated by SANADC at the start of every business week and sent to the respective subacute hospitals, wards or programs. To ensure error numbers remain low and that sites can efficiently address error records as close to patient separation as possible, it is strongly advised that all errors are addressed within the week before the next weekly reporting cycle commences.

5.3.6 Data Quality Edit Logic

A detailed listing of the edit logic for each edit that may appear in your Data Quality Edit Report is available in *Appendix 6: SANADC Data Quality Edits*. At first, it can take some time and concentration to understand why an edit is being triggered. However, frequent review of Data Quality Edit Reports will improve your efficiency in addressing data quality errors.

As AN-SNAP grouping is dependent on accurate completion of all necessary data items, there are three Golden Rules a data enterer must be mindful of:

1. If a field is blank or missing, it will trigger an error.
2. If a field is inconsistent with admission and separation dates, it will trigger an error.
3. If a field is outside the range of acceptable values for that field, it will trigger an error.

5.3.7 Providing Feedback about Data Quality Edit Reports

Data Quality Edit Reports are a communication tool that supports two way feedback. If you believe there are any deficiencies, ambiguities or problems with the format, structure or content of your Data Quality Edit Report please do not hesitate to contact SANADC with your feedback. Contact details for SANADC can be found in Section 2: Contacts and Key Links.

SECTION 6: UNDERSTANDING DATA ELEMENT DEFINITIONS

6.1 Overview

This section provides specific information about every data element captured in the SANADC, including definitions, permitted values, applicable business rules and practical data collection information.

Data is analysed across Australia, it is important that the same definitions are used for terms such as hospital, patient, admission and discharge. In most instances, the terms used in this manual are consistent with those used in the National Health Data Dictionary (NHDD) or the Admitted Subacute and Non-Acute Hospital Care Data Set Specification, available on METeOR. METeOR is an AIHW website which contains national metadata standards for health, housing and community services statistics and information.

This section provides definitions for each data element reported to SANADC and is divided into two sections:

- Non-Clinical Data Element Definitions
- Clinical Data Element Definitions.

The Non-Clinical Data Element Definitions incorporate all data elements that are deemed to be non-clinical and would generally be captured through normal administrative processes.

The Clinical Data Element Definitions incorporate all data elements that would normally be captured by clinical personnel during the episode for the purpose of clinical patient care and management.

Within both sections, the data element definitions are listed alphabetically.

6.1.1 Data Element Definition Format

A standardised format has been applied to each data element. This format ensures that relevant information is presented consistently and efficiently to the reader. The following provides a definitional overview of the format:

DATA ELEMENT TITLE

Data element name:	*Specifies the official name of the data element in line with the SANADC. The term data element may also be referred to as 'field' or 'data item'.*
Definition:	*Specifies the definition of the data element.*
Collection requirement:	*Specifies whether the item must be provided for every case or only applies under special circumstances. The types of collection requirements for HMDS include:* • *Mandatory – must be collected* • *Mandatory where applicable – must be collected where certain conditions are met* • *Not mandatory – collection is optional*
METeOR reference:	*Specifies the six-digit data item number of the equivalent data item in the NHDD or relevant Data Set Specification (DSS). This field is hyperlinked for ease of reference.*

Format:	*Specifies the format of the data element in relation to how it must be submitted to HMDS.*
Maximum length:	*Specifies the maximum length of the field in relation to how it must be submitted to HMDS.*
Permitted values:	*Specifies the permitted values to be entered. The term 'permitted values' may also be know as 'data domain'. Where there is a large number of Permitted Values, the reader is referred to the Appendices.*

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SECTION 7: NON-CLINICAL DATA ELEMENT DEFINITIONS

Account / Admission Number

Data element name:	Account/Admission Number
Definition:	The unique identifier of a hospital episode of care that may be used for billing.
Collection requirement:	Mandatory for all subacute care types
METeOR reference:	Not applicable
Format:	Character
Maximum length:	12
Permitted values:	Alpha/numeric combination up to 12 characters

GUIDE FOR USE

- The Account/Admission Number can be alphanumeric or numeric up to a maximum of 12 characters.

EXAMPLES

Example 1: A patient was admitted to a hospital and assigned 9203148 as an Account Number.

Account / Admission Number	9	2	0	3	1	4	8					

Example 2: A patient was admitted to hospital and assigned AB945793 as the Account Number.

Account / Admission Number	A	B	9	4	5	7	9	3				

DATA QUALITY

All data quality performed on this data item is incorporated in the HMDS data quality process. Please refer to the latest HMDS Reference Manual for specific edits pertaining to this field.

The SANADC may identify is discrepancies or duplication of Account Numbers and will contact the responsible site for follow-up and subsequent correction.

Admission Date

Data element name:	Admission Date
Definition:	The date on which an admitted patient commences an episode of care that can be formal or statistical.
Collection requirement:	Mandatory for all subacute care types
METeOR reference:	269967
Format:	Date
Maximum length:	8
Permitted values:	DDMMYYYY

GUIDE FOR USE

- Enter the full date of admission, including leading zeros where necessary.

Formal Admission

- A formal admission is an administrative process that initiates a record of the patient's treatment and accommodation within a hospital.
- The Admission Date for a formal admission will be the date the hospital commenced treatment and accommodation of the patient.

Statistical Admission

- A statistical admission is an administrative process that occurs within an episode of care and captures the commencement of a particular type of care (Care Type).
- The Admission Date for a statistical admission will be the date the patient commenced a particular Care Type.

DATA QUALITY

All data quality performed on this data item is incorporated in the HMDS data quality process. Please refer to the latest HMDS Reference Manual for specific edits pertaining to this field.

Admission for Assessment Only

Data element name:	Admission for Assessment Only
Definition:	An indicator of whether an episode of admitted patient care resulted in the patient undergoing a clinical assessment only, as represented by a code.
Collection requirement:	Conditional
METeOR reference:	471807
Format:	Numeric
Maximum length:	1
Permitted values:	1 – Yes 2 – No 9 – Unknown

GUIDE FOR USE

- If valid value = 1 – Yes (patient assessed by clinical team but no further treatment or intervention was provided), then FIM is NOT mandatory.
- If valid value = 2 – No (patient assessed by clinical team but further treatment or intervention was provided), then FIM and Impairment Type is mandatory.

VALUE DEFINITIONS

1 – Yes

This category should be used when the patient undergoes a clinical assessment only, no further treatment or intervention is provided.

2 – No

This category should be used when the patient undergoes a clinical assessment but further treatment or intervention is provided.

3 – Unknown

This category should be used when it is not known whether the episode of admitted care resulted in the patient undergoing a clinical assessment only.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
9000	Assessment only answer is missing	Critical

Edit Number	Edit Message	Edit Severity
9001	Assessment only answer is invalid	Critical

Assessment Date

Data element name:	Assessment Date
Definition:	The date on which the patient was assessed against the functional tool associated with the patient's subacute/non-acute care type.
Collection requirement:	Mandatory
METeOR reference:	Not applicable
Format:	Date
Maximum length:	8
Permitted values:	DDMMYYYY

GUIDE FOR USE

- Rehabilitation and GEM patients are assessed against the FIM instrument. Psychogeriatric patients are assessed against the HoNOS 65+ Scale and Palliative and Maintenance patients are assessed against the RUG-ADL tool.
- The Assessment Date must reflect the date upon which the patient was assessed against the relevant functional tool.
- The Assessment Date must not be before the Admission Date or after the Separation Date.
- For Palliative Care episodes, there must be a RUG-ADL Assessment Date reported for each Phase of Care.
- For Rehabilitation and GEM patients assessed against the FIM instrument, the Assessment must be completed within 72 hours of admission unless the patient has been admitted for assessment only.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1002	FIM assessment date is missing	Critical
1003	FIM assessment date is prior to admission date	Critical
1004	FIM assessment date is after separation date	Critical
1005	FIM assessment is not within 72 hours of the start of the episode of care	Critical
3002	HoNOS 65+ assessment date is missing	Critical
3003	HoNOS 65+ assessment date is prior to admission date	Critical
3004	HoNOS 65+ assessment date is after separation date	Critical

Edit Number	Edit Message	Edit Severity
4003	RUG-ADL assessment date is missing for maintenance episode	Critical
4004	RUG-ADL assessment date is prior to admission date for maintenance episode	Critical
4005	RUG-ADL assessment date is after the separation date for maintenance episode	Critical
5010	RUG-ADL assessment date is before phase of care start date	Critical
5011	RUG-ADL assessment date is after phase of care end date	Critical
5014	RUG-ADL assessment date is missing for palliative phase	Critical
5015	RUG-ADL phase assessment date is prior to admission date for palliative episode	Critical
5016	RUG-ADL phase assessment date is after the separation date for palliative episode	Critical

Client Identifier - Unit Medical Record Number

Data element name:	Client Identifier or Unit Medical Record Number
Definition:	Person identifier unique within an establishment
Collection requirement:	Mandatory
METeOR reference:	290046
Format:	Character
Maximum length:	10
Permitted values:	Alpha/numeric combination up to 10 characters

GUIDE FOR USE

- The Client Identifier can be alphanumeric or numeric up to a maximum of 10 characters. The year number should not form any part of the Client Identifier.
- Alternate names for the Client Identifier include Unit Medical Record Number (UMRN) or Unit Record Number (URN).
- The same Client Identifier is retained by the hospital for the patient for all admissions within a particular hospital.

EXAMPLE

UMRN 271864 is entered as

Client Identifier	2	7	1	8	6	4				

DATA QUALITY EDITS

All data quality performed on this data item is incorporated in the HMDS data quality process. Please refer to the latest HMDS Reference Manual for specific edits pertaining to this field.

Establishment

Data element name:	Establishment (Hospital/Health Service)
Definition:	A unique four-digit number that is assigned globally by HMDS to each establishment that is required to report admitted activity information to the HMDS. The Establishment Code is an identifier for a reporting hospital.
Collection requirement:	Mandatory
METeOR reference:	269973
Format:	Number
Maximum length:	4
Permitted values:	See *Appendix 1: SANADC Reporting Establishments List*

GUIDE FOR USE

- A list of valid hospital and health service establishments for subacute/non-acute reporting purposes is provided in *Appendix 1: SANADC Reporting Establishments List*.
- The establishments listed in *Appendix 1: SANADC Reporting Establishments List* are hospitals or health services that are required to report their subacute activity data to the SANADC because they have one or more wards that are designated to provide subacute care.
- Each organisation must only have one Establishment Code assigned.

EXAMPLES

Example 1: A patient was admitted to Armadale Kelmscott District Memorial Hospital.

Establishment	0	2	0	3

Example 2: A patient was admitted to St John of God Health Care Murdoch.

Establishment	0	6	4	0

DATA QUALITY EDITS

All data quality performed on this data item is incorporated in the HMDS data quality process. Please refer to the latest HMDS Reference Manual for specific edits pertaining to this field.

Separation Date

Data element name:	Separation Date
Definition:	The date on which an admitted patient completes an episode of care. The patient can be formally or statistically discharged from hospital. If a patient dies in hospital, the separation date is the date of death.
Collection requirement:	Mandatory
METeOR reference:	270025
Format:	Date
Maximum length:	8
Permitted values:	DDMMYYYY

GUIDE FOR USE

- Enter the full date of separation, including leading zeros where necessary.
- If an admitted patient is on leave but does not return after 7 days the patient is then formally discharged on the 7th day, and the preceding days are counted as leave days.

Formal Separation/Discharge

- A formal separation/discharge is an administrative process that ceases a record of the patient's treatment and accommodation within a hospital.
- The Separation Date for a formal separation/discharge will be the date the hospital completed treatment and accommodation of the patient.

Statistical Separation/Discharge

- A statistical separation/discharge is an administrative process that occurs within an episode of care and captures the end date the patient received a particular type of care (Care Type).
- The Separation Date for a statistical admission will be the date the patient completed a particular Care Type.

EXAMPLES

Example 1: A patient was discharged from hospital on 1st July 2015.

Separation Date	0	1	0	7	2	0	1	5

Example 2: A patient was transferred from hospital on 20th February 2015.

Separation Date	2	0	0	2	2	0	1	5

Example 3: A patient died on 23rd March 2015.

Separation Date	2	3	0	3	2	0	1	5

DATA QUALITY EDITS

All data quality performed on this data item is incorporated in the HMDS data quality process. Please refer to the latest HMDS Reference Manual for specific edits pertaining to this field.

Ward / Location

Data element name:	Ward/Location
Definition:	The ward or unit within the hospital where the patient was being treated immediately prior to discharge.
Collection requirement:	Mandatory
METeOR reference:	Not applicable
Format:	Character
Maximum length:	20
Permitted values:	Free text up to 20 characters

GUIDE FOR USE

- A person can receive subacute and non-acute care in any hospital ward, however for reporting to the SANADC only hospitals with designated subacute/non-acute wards are mandated to report subacute clinical assessment information.
- Refer to *Appendix 2: SANAC Designated Ward Listing* for a current listing of all designated subacute wards.
- Please note that there are no wards designated for the delivery of Maintenance Care. There are currently no restrictions on where Maintenance Care can be delivered.

Designated Wards

A designated ward is a ward that is dedicated to providing care for patients receiving a specific subacute Care Type. A ward is considered designated if the majority of subacute services that it provides under a specific subacute care type are:

- Delivered under the management of or informed by a clinician with specialised expertise in a subacute care type
- Evidenced by a care type change
- Provided in accordance with an individualised, multidisciplinary management plan
- Involves formal assessment of functional ability within 72 hours of admission
- Recorded in both the medical record and applicable information register e.g. QoCR.

A subacute service provided on a ward must comply with the all of the above criteria in order to be designated.

If a hospital identifies that a particular ward meets all criteria to be a Designated Ward, then they should contact the Health Reform and the SANADC to discuss qualification and reporting arrangements. Contact information can be found in Contact Details.

Non-Designated Wards

A non-designated ward is a ward that is not dedicated to providing care for patient receiving a specific subacute Care Type or the ward is dedicated only in part and does not comply with all of the above criteria for designation.

DATA QUALITY EDITS

All data quality performed on this data item is incorporated in the HMDS data quality process. Please refer to the latest HMDS Reference Manual for specific edits pertaining to this field.

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SECTION 8: CLINICAL DATA ELEMENT DEFINITIONS

FIM – Eating (on Admission)

Data element name:	FIM Eating
Definition:	The patient's Functional Independence Measure score for eating, assessed at the time of admission.
Collection requirement:	Mandatory for Rehabilitation Care and GEM Care episodes only
METeOR reference:	495857
Format:	Numeric
Maximum length:	1
Permitted values:	1 – Total assistance with helper 2 – Maximal assistance with helper 3 – Moderate assistance with helper 4 – Minimal assistance with helper 5 – Supervision or setup with helper 6 – Modified independence with helper 7 – Complete independence

GUIDE FOR USE

- A FIM Eating score:
    - Is only required for Rehabilitation and GEM care types
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected within 72 hours of the start of a Rehabilitation or GEM episode
    - Must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admeat41/index.html.
- The data element is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1006	FIM assessment score(s) is not in range	Critical

FIM – Grooming (on Admission)

Data element name:	FIM Grooming
Definition:	The patient's Functional Independent Measure score for grooming, assessed at the time of admission.
Collection requirement:	Mandatory for Rehabilitation Care and GEM Care episodes only
METeOR reference:	495857
Format:	Numeric
Maximum length:	1
Permitted values:	1 – Total assistance with helper 2 – Maximal assistance with helper 3 – Moderate assistance with helper 4 – Minimal assistance with helper 5 – Supervision or setup with helper 6 – Modified independence with helper 7 – Complete independence

GUIDE FOR USE

- A FIM Grooming score:
    - Is only required for Rehabilitation and GEM care types
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected within 72 hours of the start of a Rehabilitation or GEM episode
    - Must be captured in accordance with AROC data collection requirements. Must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admgroom42/index.html.
- The data element is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1006	FIM assessment score(s) is not in range	Critical

FIM – Bathing (on Admission)

Data element name:	FIM Bathing
Definition:	The patient's Functional Independence Measure score for bathing, assessed at the time of admission.
Collection requirement:	Mandatory for Rehabilitation Care and GEM Care episodes only
METeOR reference:	495857
Format:	Numeric
Maximum length:	1
Permitted values:	1 – Total assistance with helper 2 – Maximal assistance with helper 3 – Moderate assistance with helper 4 – Minimal assistance with helper 5 – Supervision or setup with helper 6 – Modified independence with helper 7 – Complete independence

GUIDE FOR USE

- A FIM Bathing score:
    - Is only required for Rehabilitation and GEM care types
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected within 72 hours of the start of a Rehabilitation or GEM episode
    - Must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admbath43/index.html.
- The data element is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1006	FIM assessment score(s) is not in range	Critical

FIM – Dressing Upper Body (on Admission)

Data element name:	FIM Dressing Upper Body
Definition:	The patient's Functional Independence Measure score for dressing upper body, assessed at the time of admission.
Collection requirement:	Mandatory for Rehabilitation Care and GEM Care episodes only
METeOR reference:	495857
Format:	Numeric
Maximum length:	1
Permitted values:	1 – Total assistance with helper 2 – Maximal assistance with helper 3 – Moderate assistance with helper 4 – Minimal assistance with helper 5 – Supervision or setup with helper 6 – Modified independence with helper 7 – Complete independence

GUIDE FOR USE

- A FIM Dressing Upper Body score:
    - Is only required for Rehabilitation and GEM care types
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected within 72 hours of the start of a Rehabilitation or GEM episode
    - Must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admupper44/index.html.
- The data element is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1006	FIM assessment score(s) is not in range	Critical

FIM – Dressing Lower Body (on Admission)

Data element name:	FIM Dressing Lower Body
Definition:	The patient's Functional Independence Measure score for dressing lower body, assessed at the time of admission.
Collection requirement:	Mandatory for Rehabilitation Care and GEM Care episodes only
METeOR reference:	495857
Format:	Numeric
Maximum length:	1
Permitted values:	1 – Total assistance with helper 2 – Maximal assistance with helper 3 – Moderate assistance with helper 4 – Minimal assistance with helper 5 – Supervision or setup with helper 6 – Modified independence with helper 7 – Complete independence

GUIDE FOR USE

- A FIM Dressing Lower Body score:
    - Is only required for Rehabilitation and GEM care types
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected within 72 hours of the start of a Rehabilitation or GEM episode
    - Must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admlower45/index.html.
- The data element is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1006	FIM assessment score(s) is not in range	Critical

FIM – Toileting (on Admission)

Data element name:	FIM Toileting
Definition:	The patient's Functional Independence Measure score for toileting, assessed at the time of admission.
Collection requirement:	Mandatory for Rehabilitation Care and GEM Care episodes only
METeOR reference:	495857
Format:	Numeric
Maximum length:	1
Permitted values:	1 – Total assistance with helper 2 – Maximal assistance with helper 3 – Moderate assistance with helper 4 – Minimal assistance with helper 5 – Supervision or setup with helper 6 – Modified independence with helper 7 – Complete independence

GUIDE FOR USE

- A FIM Toileting score:
    - Is only required for Rehabilitation and GEM care types
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected within 72 hours of the start of a Rehabilitation or GEM episode
    - Must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admtoilet46/index.html.
- The data element is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1006	FIM assessment score(s) is not in range	Critical

FIM – Bladder Management (on Admission)

Data element name:	FIM Bladder Management
Definition:	The patient's Functional Independence Measure score for bladder management, assessed at the time of admission.
Collection requirement:	Mandatory for Rehabilitation Care and GEM Care episodes only
METeOR reference:	495857
Format:	Numeric
Maximum length:	1
Permitted values:	1 – Total assistance with helper 2 – Maximal assistance with helper 3 – Moderate assistance with helper 4 – Minimal assistance with helper 5 – Supervision or setup with helper 6 – Modified independence with helper 7 – Complete independence

GUIDE FOR USE

- A FIM Bladder Management score:
    - Is only required for Rehabilitation and GEM care types
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected within 72 hours of the start of a Rehabilitation or GEM episode
    - Must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admbladder47/index.html.
- The data element is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1006	FIM assessment score(s) is not in range	Critical

FIM – Bowel Management (on Admission)

Data element name:	FIM Bowel Management
Definition:	The patient's Functional Independence Measure score for bowel management, assessed at the time of admission.
Collection requirement:	Mandatory for Rehabilitation Care and GEM Care episodes only
METeOR reference:	495857
Format:	Numeric
Maximum length:	1
Permitted values:	1 – Total assistance with helper 2 – Maximal assistance with helper 3 – Moderate assistance with helper 4 – Minimal assistance with helper 5 – Supervision or setup with helper 6 – Modified independence with helper 7 – Complete independence

GUIDE FOR USE

- A FIM Bowel Management score:
    - Is only required for Rehabilitation and GEM care types
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected within 72 hours of the start of a Rehabilitation or GEM episode
    - Must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admbowel48/index.html.
- The data element is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1006	FIM assessment score(s) is not in range	Critical

FIM – Transfer to Bed/Chair (on Admission)

Data element name:	FIM Transfer to bed/chair
Definition:	The patient's Functional Independence Measure score for transfer to bed, chair or wheelchair, assessed at the time of admission.
Collection requirement:	Mandatory for Rehabilitation Care and GEM Care episodes only
METeOR reference:	495857
Format:	Numeric
Maximum length:	1
Permitted values:	1 – Total assistance with helper 2 – Maximal assistance with helper 3 – Moderate assistance with helper 4 – Minimal assistance with helper 5 – Supervision or setup with helper 6 – Modified independence with helper 7 – Complete independence

GUIDE FOR USE

- A FIM Transfer to Bed/Chair score:
    - Is only required for Rehabilitation and GEM care types
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected within 72 hours of the start of a Rehabilitation or GEM episode
    - Must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admxfer49/index.html.
- The data element is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1006	FIM assessment score(s) is not in range	Critical

FIM – Transfer to Toilet (on Admission)

Data element name:	FIM Transfer to toilet
Definition:	The patient's Functional Independence Measure score for transfer to toilet, assessed at the time of admission.
Collection requirement:	Mandatory for Rehabilitation Care and GEM Care episodes only
METeOR reference:	495857
Format:	Numeric
Maximum length:	1
Permitted values:	1 – Total assistance with helper 2 – Maximal assistance with helper 3 – Moderate assistance with helper 4 – Minimal assistance with helper 5 – Supervision or setup with helper 6 – Modified independence with helper 7 – Complete independence

GUIDE FOR USE

- A FIM Transfer to Toilet score:
    - Is only required for Rehabilitation and GEM care types
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected within 72 hours of the start of a Rehabilitation or GEM episode
    - Must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admxfrtoil50/index.html.
- The data element is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1006	FIM assessment score(s) is not in range	Critical

FIM – Transfer to Shower/Bath (on Admission)

Data element name:	FIM Transfer to shower/bath
Definition:	The patient's Functional Independence Measure score for transfer to shower/bath, assessed at the time of admission.
Collection requirement:	Mandatory for Rehabilitation Care and GEM Care episodes only
METeOR reference:	495857
Format:	Numeric
Maximum length:	1
Permitted values:	1 – Total assistance with helper 2 – Maximal assistance with helper 3 – Moderate assistance with helper 4 – Minimal assistance with helper 5 – Supervision or setup with helper 6 – Modified independence with helper 7 – Complete independence

GUIDE FOR USE

- A FIM Transfer to Shower/Bath score:
    - Is only required for Rehabilitation and GEM care types
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected within 72 hours of the start of a Rehabilitation or GEM episode
    - Must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admtub51/index.html.
- The data element is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1006	FIM assessment score(s) is not in range	Critical

FIM – Locomotion (on Admission)

Data element name:	FIM Locomotion
Definition:	The patient's Functional Independence Measure score for locomotion, assessed at the time of admission.
Collection requirement:	Mandatory for Rehabilitation Care and GEM Care episodes only
METeOR reference:	495857
Format:	Numeric
Maximum length:	1
Permitted values:	1 – Total assistance with helper 2 – Maximal assistance with helper 3 – Moderate assistance with helper 4 – Minimal assistance with helper 5 – Supervision or setup with helper 6 – Modified independence with helper 7 – Complete independence

GUIDE FOR USE

- A FIM Locomotion score:
    - Is only required for Rehabilitation and GEM care types
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected within 72 hours of the start of a Rehabilitation or GEM episode
    - Must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admwalk52/index.html.
- The data element is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1006	FIM assessment score(s) is not in range	Critical

FIM – Stairs (on Admission)

Data element name:	FIM Stairs
Definition:	The patient's Functional Independence Measure score for managing stairs, assessed at the time of admission.
Collection requirement:	Mandatory for Rehabilitation Care and GEM Care episodes only
METeOR reference:	495857
Format:	Numeric
Maximum length:	1
Permitted values:	1 – Total assistance with helper 2 – Maximal assistance with helper 3 – Moderate assistance with helper 4 – Minimal assistance with helper 5 – Supervision or setup with helper 6 – Modified independence with helper 7 – Complete independence

GUIDE FOR USE

- A FIM Stairs score:
    - Is only required for Rehabilitation and GEM care types
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected within 72 hours of the start of a Rehabilitation or GEM episode
    - Must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admstair53/index.html.
- The data element is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1006	FIM assessment score(s) is not in range	Critical

FIM – Comprehension (on Admission)

Data element name:	FIM Comprehension
Definition:	The patient's Functional Independence Measure score for comprehension, assessed at the time of admission.
Collection requirement:	Mandatory for Rehabilitation Care and GEM Care episodes only
METeOR reference:	495857
Format:	Numeric
Maximum length:	1
Permitted values:	1 – Total assistance with helper 2 – Maximal assistance with helper 3 – Moderate assistance with helper 4 – Minimal assistance with helper 5 – Supervision or setup with helper 6 – Modified independence with helper 7 – Complete independence

GUIDE FOR USE

- A FIM Comprehension score:
    - Is only required for Rehabilitation and GEM care types
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected within 72 hours of the start of a Rehabilitation or GEM episode
    - Must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admcomp54/index.html.
- The data element is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1006	FIM assessment score(s) is not in range	Critical

FIM – Expression (on Admission)

Data element name:	FIM Expression
Definition:	The patient's Functional Independence Measure score for expression, assessed at the time of admission.
Collection requirement:	Mandatory for Rehabilitation Care and GEM Care episodes only
METeOR reference:	495857
Format:	Numeric
Maximum length:	1
Permitted values:	1 – Total assistance with helper 2 – Maximal assistance with helper 3 – Moderate assistance with helper 4 – Minimal assistance with helper 5 – Supervision or setup with helper 6 – Modified independence with helper 7 – Complete independence

GUIDE FOR USE

- A FIM Expression score:
    - Is only required for Rehabilitation and GEM care types
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected within 72 hours of the start of a Rehabilitation or GEM episode
    - Must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admexp55/index.html.
- The data element is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1006	FIM assessment score(s) is not in range	Critical

FIM – Social Interaction (on Admission)

Data element name:	FIM Social Interaction
Definition:	The patient's Functional Independence Measure score for social interaction, assessed at the time of admission.
Collection requirement:	Mandatory for Rehabilitation Care and GEM Care episodes only
METeOR reference:	495857
Format:	Numeric
Maximum length:	1
Permitted values:	1 – Total assistance with helper 2 – Maximal assistance with helper 3 – Moderate assistance with helper 4 – Minimal assistance with helper 5 – Supervision or setup with helper 6 – Modified independence with helper 7 – Complete independence

GUIDE FOR USE

- A FIM Social Interaction score:
    - Is only required for Rehabilitation and GEM care types
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected within 72 hours of the start of a Rehabilitation or GEM episode
    - Must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admsocial56/index.html.
- The data element is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1006	FIM assessment score(s) is not in range	Critical

FIM – Problem Solving (on Admission)

Data element name:	FIM Problem solving
Definition:	The patient's Functional Independence Measure score for problem solving, assessed at the time of admission.
Collection requirement:	Mandatory for Rehabilitation Care and GEM Care episodes only
METeOR reference:	495857
Format:	Numeric
Maximum length:	1
Permitted values:	1 – Total assistance with helper 2 – Maximal assistance with helper 3 – Moderate assistance with helper 4 – Minimal assistance with helper 5 – Supervision or setup with helper 6 – Modified independence with helper 7 – Complete independence

GUIDE FOR USE

- A FIM Problem Solving score:
    - Is only required for Rehabilitation and GEM care types
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected within 72 hours of the start of a Rehabilitation or GEM episode
    - Must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admprob57/index.html.
- The data element is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1006	FIM assessment score(s) is not in range	Critical

FIM – Memory (on Admission)

Data element name:	FIM Memory
Definition:	The patient's Functional Independence Measure score for memory, assessed at the time of admission.
Collection requirement:	Mandatory for Rehabilitation Care and GEM Care episodes only
METeOR reference:	495857
Format:	Numeric
Maximum length:	1
Permitted values:	1 – Total assistance with helper 2 – Maximal assistance with helper 3 – Moderate assistance with helper 4 – Minimal assistance with helper 5 – Supervision or setup with helper 6 – Modified independence with helper 7 – Complete independence

GUIDE FOR USE

- A FIM Memory score:
    - Is only required for Rehabilitation and GEM care types
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected within 72 hours of the start of a Rehabilitation or GEM episode
    - Must be captured in accordance with AROC data collection requirements. These can be found at: http://ahsri.uow.edu.au/aroc/inp3au/admmemory58/index.html.
- The data element is scored on a 7 point ordinal scale, ranging from a score of 1 to a score of 7. The higher the score, the more independent the patient is in performing the task.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
1000	FIM assessment is missing	Critical
1001	FIM assessment is not complete	Critical
1006	FIM assessment score(s) is not in range	Critical

HoNOS 65+ Behavioural Disturbance (on Admission)

Data element name:	HoNOS 65+ Behavioural Disturbance
Definition:	A clinical measure of behavioural disturbance occurring in the period rated for a patient receiving psychogeriatric care.
Collection requirement:	Mandatory for Psychogeriatric Care episodes only
METeOR reference:	495880
Format:	Numeric
Maximum length:	1
Permitted values:	0 – No problems within the stated period 1 – Minor problem requiring no action 2 – Mild problem but definitely present 3 – Moderately severe problem 4 – Severe to very severe problem

GUIDE FOR USE

- A HoNOS 65+ Behavioural Disturbance score:
    - Is only required where the care type is Psychogeriatric
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected at the start of a Psychogeriatric episode
    - Must be captured in accordance with the NOCC data collection requirements for the HoNOS 65+ tool that is administered by the AMHCON. These can be found at: http://amhocn.org/home/useful-resources/national-outcomes-and-casemix-collection-nocc.
- The rating period is generally the preceding two weeks for inpatients at admission (AMHCON 2014).

VALID VALUES

The following Value definitions have been sourced from the NOCC – Glossaries for NOCC Measures (AMHCON 2014):

0 – No problems within the stated period

The patient did not exhibit problems of this kind during the period rated.

1 – Minor problem requiring no action

The patient has exhibited occasional irritability, quarrels, restlessness etc., but is generally calm and cooperative and not requiring any specific action.

2 – Mild problem but definitely present

The patient has exhibited one or more of the following:

- Aggressive gestures
- Pushing or pestering others
- Threats or verbal aggression
- Mild damage to property (e.g. broken cup, window)
- Significant overactivity or agitation
- Intermittent restlessness or wandering (day or night)
- Uncooperative at times, requiring encouragement and persuasion.

3 – Moderately severe problem

The patient has exhibited one or more of the following:

- Physical aggression to others or animals
- Serious damage to, or destruction of property
- Frequently threatening manner
- Serious or persistent overactivity or agitation
- Frequent restlessness or wandering
- Significant problems with Cupertino
- Largely resistant to help or assistance.

4 – Severe to very severe problem

The patient has exhibited one or more of the following:

- Made at least one serious physical attack on others
- Major or persistent destructive activity (e.g. fire-setting)
- Persistent and threatening behaviour
- Severe overactivity or agitation
- Sexually disinhibited or other inappropriate urination or defecation
- Virtually constant restlessness or wandering
- Severe problems related to non-compliant or resistive behaviour.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
3000	HoNOS 65+ assessment is missing	Critical
3001	HoNOS 65+ assessment is not complete	Critical
3005	HoNOS 65+ assessment score(s) is not in range	Critical

HoNOS 65+ Non-accidental Self Injury (on Admission)

Data element name:	HoNOS 65+ Non-accidental Self Injury
Definition:	A clinical measure of non-accidental, self inflicted injury or injuries occurring in the period rated for a patient receiving psychogeriatric care.
Collection requirement:	Mandatory for Psychogeriatric Care episodes only
METeOR reference:	495880
Format:	Numeric
Maximum length:	1
Permitted values:	0 – No problems within the stated period 1 – Minor problem requiring no action 2 – Mild problem but definitely present 3 – Moderately severe problem 4 – Severe to very severe problem

GUIDE FOR USE

- A HoNOS 65+ Non-accidental Self Injury score:
    - Is only required where the care type is Psychogeriatric
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected at the start of a Psychogeriatric episode
    - Must be captured in accordance with the NOCC data collection requirements for the HoNOS 65+ tool that is administered by the AMHCON. These can be found at: http://amhocn.org/home/useful-resources/national-outcomes-and-casemix-collection-nocc.
- The rating period is generally the preceding two weeks for inpatients at admission (AMHCON 2014).

VALID VALUES

The following Value definitions have been sourced from the NOCC – Glossaries for NOCC Measures (AMHCON 2014):

0 – No problems within the stated period

The patient did not exhibit problems of this kind during the period rated.

1 – Minor problem requiring no action

The patient has exhibited fleeting thoughts of self–harm or suicide, but little or no risk during the period rated.

2 – Mild problem but definitely present

The patient has exhibited mild risk during the period. This includes more frequent thoughts or talking about self–harm or suicide (including 'passive' ideas of self–harm such as not taking avoiding action in a potentially life–threatening situation, e.g. while crossing a road).

3 – Moderately severe problem

The patient has exhibited moderate to serious risk of deliberate self–harm during the period rated. This includes frequent or persistent thoughts or talking about self–harm and includes preparatory behaviours e.g. collecting tablets.

4 – Severe to very severe problem

The patient attempted suicide or deliberate self–injury during the period rated.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
3000	HoNOS 65+ assessment is missing	Critical
3001	HoNOS 65+ assessment is not complete	Critical
3005	HoNOS 65+ assessment score(s) is not in range	Critical

HoNOS 65+ Problem Drinking or Drug use (on Admission)

Data element name:	HoNOS 65+ Problem Drinking or Drug Taking
Definition:	A clinical measure of problem drinking or drug taking occurring in the period rated for a patient receiving psychogeriatric care.
Collection requirement:	Mandatory for Psychogeriatric Care episodes only
METeOR reference:	495880
Format:	Numeric
Maximum length:	1
Permitted values:	0 – No problems within the stated period 1 – Minor problem requiring no action 2 – Mild problem but definitely present 3 – Moderately severe problem 4 – Severe to very severe problem

GUIDE FOR USE

- A HoNOS 65+ Problem Drinking or Drug Taking score:
    - Is only required where the care type is Psychogeriatric
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected at the start of a Psychogeriatric episode
    - Must be captured in accordance with the NOCC data collection requirements for the HoNOS 65+ tool that is administered by the AMHCON. These can be found at: http://amhocn.org/home/useful-resources/national-outcomes-and-casemix-collection-nocc.
- The rating period is generally the preceding two weeks for inpatients at admission (AMHCON 2014).

VALID VALUES

The following Value definitions have been sourced from the NOCC – Glossaries for NOCC Measures (AMHCON 2014):

0 – No problems within the stated period

The patient did not exhibit problems of this kind during the period rated.

1 – Minor problem requiring no action

The patient has exhibited some over-indulgence but within social norms.

2 – Mild problem but definitely present

The patient has exhibited occasional loss of control of drinking or drug-taking but not a serious problem.

3 – Moderately severe problem

The patient has exhibited marked craving for or dependence on alcohol or drugs with frequent loss of control, drunkenness etc.

4 – Severe to very severe problem

The patient has exhibited major adverse consequences or was incapacitated due to alcohol or drug problems.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
3000	HoNOS 65+ assessment is missing	Critical
3001	HoNOS 65+ assessment is not complete	Critical
3005	HoNOS 65+ assessment score(s) is not in range	Critical

HoNOS 65+ Cognitive Problems (on Admission)

Data element name:	HoNOS 65+ Cognitive Problems
Definition:	A clinical measure of cognitive problems occurring in the period rated for a patient receiving psychogeriatric care.
Collection requirement:	Mandatory for Psychogeriatric Care episodes only
METeOR reference:	495880
Format:	Numeric
Maximum length:	1
Permitted values:	0 – No problems within the stated period 1 – Minor problem requiring no action 2 – Mild problem but definitely present 3 – Moderately severe problem 4 – Severe to very severe problem

GUIDE FOR USE

- A HoNOS 65+ Cognitive Problems score:
    - Is only required where the care type is Psychogeriatric
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected at the start of a Psychogeriatric episode
    - Must be captured in accordance with the NOCC data collection requirements for the HoNOS 65+ tool that is administered by the AMHCON. These can be found at: http://amhocn.org/home/useful-resources/national-outcomes-and-casemix-collection-nocc.
- The rating period is generally the preceding two weeks for inpatients at admission (AMHCON 2014).

VALID VALUES

The following Value definitions have been sourced from the NOCC – Glossaries for NOCC Measures (AMHCON 2014):

0 – No problems within the stated period

The patient did not exhibit problems of this kind during the period rated.

1 – Minor problem requiring no action

The patient has exhibited one or more of the following problems:

- Minor problems with orientation (e.g. some difficulty with orientation to time).

- Minor problems with memory (e.g. a degree of forgetfulness but still able to learn new information).
- No apparent difficulties with the use of language.

2 – Mild problem but definitely present

The patient has exhibited one or more of the following:

- Mild problems with orientation (e.g. frequently disorientated to time).
- Mild problems with memory (e.g. definite problems learning new information such as names, recollection of recent events; deficit interferes with everyday activities).
- Difficulty finding way in new or unfamiliar surroundings.
- Able to deal with simple verbal information but some difficulties with understanding or expression of more complex language.

3 – Moderately severe problem

The patient has exhibited one or more of the following:

- Moderate problems with orientation (e.g. usually disorientated to time, often place).
- Moderate problems with memory (e.g. new material rapidly lost, only highly learned material retained, occasional failure to recognise familiar individuals).
- Has lost their way in a familiar place.
- Major difficulties with language (expressive or receptive).

4 – Severe to very severe problem

The patient has exhibited one or more of the following:

- Severe disorientation (e.g. consistently disorientated to time and place and sometimes to person).
- Severe memory impairment (e.g. only fragments remain, loss of distant as well as recent information, unable to effectively learn any new information, consistently unable to recognise or to name close friends or relatives).
- No effective communication possible through language or inaccessible to speech.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
3000	HoNOS 65+ assessment is missing	Critical
3001	HoNOS 65+ assessment is not complete	Critical
3005	HoNOS 65+ assessment score(s) is not in range	Critical

HoNOS 65+ Problems related to Physical Illness or Disability (on Admission)

Data element name:	HoNOS 65+ Physical Illness or Disability Problems
Definition:	A clinical measure of physical illness or disability problems occurring in the period rated for a patient receiving psychogeriatric care.
Collection requirement:	Mandatory for Psychogeriatric Care episodes only
METeOR reference:	495880
Format:	Numeric
Maximum length:	1
Permitted values:	0 – No problems within the stated period 1 – Minor problem requiring no action 2 – Mild problem but definitely present 3 – Moderately severe problem 4 – Severe to very severe problem

GUIDE FOR USE

- A HoNOS 65+ Physical Illness or Disability Problems score:
    - Is only required where the care type is Psychogeriatric
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected at the start of a Psychogeriatric episode
    - Must be captured in accordance with the NOCC data collection requirements for the HoNOS 65+ tool that is administered by the AMHCON. These can be found at: http://amhocn.org/home/useful-resources/national-outcomes-and-casemix-collection-nocc.
- The rating period is generally the preceding two weeks for inpatients at admission (AMHCON 2014).

VALID VALUES

The following Value definitions have been sourced from the NOCC – Glossaries for NOCC Measures (AMHCON 2014):

0 – No problems within the stated period

The patient did not exhibit problems of this kind during the period rated.

1 – Minor problem requiring no action

The patient has exhibited a minor health problem during the period (e.g. cold); some impairment of sight or hearing (but still able to function effectively with the aid of glasses or hearing aid).

2 – Mild problem but definitely present

The patient has exhibited one or more of the following:

- Physical health problem associated with mild restriction of activities or mobility (e.g. restricted walking distance, some degree of loss of independence).
- Moderate impairment of sight or hearing (with functional impairment despite the appropriate use of glasses or hearing aid).
- Some degree of risk of falling, but low and no episodes to date.
- Problems associated with mild degree of pain.

3 – Moderately severe problem

The patient has exhibited one or more of the following:

- Physical health problem associated with moderate restriction of activities or mobility (e.g. mobile only with an aid – stick or zimmer frame – or with help).
- More severe impairment of sight or hearing.
- Significant risk of falling (one or more falls).
- Problems associated with a moderate degree of pain.

4 – Severe to very severe problem

The patient has exhibited one or more of the following:

- A major physical health problem associated with severe restriction of activities or mobility (e.g. chair or bed bound).
- Severe impairment of sight or hearing (e.g. registered blind or deaf).
- High risk of falling (one or more falls) because of physical illness or disability.
- Problems associated with severe pain.
- Presence of impaired level of consciousness.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
3000	HoNOS 65+ assessment is missing	Critical
3001	HoNOS 65+ assessment is not complete	Critical
3005	HoNOS 65+ assessment score(s) is not in range	Critical

HoNOS 65+ Problems associated with Hallucinations and Delusions (on Admission)

Data element name:	HoNOS 65+ Problems associated with Hallucinations or Delusions
Definition:	A clinical measure of problems associated with hallucinations and delusions occurring in the period rated for a patient receiving psychogeriatric care.
Collection requirement:	Mandatory for Psychogeriatric Care episodes only
METeOR reference:	495880
Format:	Numeric
Maximum length:	1
Permitted values:	0 – No problems within the stated period 1 – Minor problem requiring no action 2 – Mild problem but definitely present 3 – Moderately severe problem 4 – Severe to very severe problem

GUIDE FOR USE

- A HoNOS 65+ Problems associated with Hallucinations or Delusions score:
    - Is only required where the care type is Psychogeriatric
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected at the start of a Psychogeriatric episode
    - Must be captured in accordance with the NOCC data collection requirements for the HoNOS 65+ tool that is administered by the AMHCON. These can be found at: http://amhocn.org/home/useful-resources/national-outcomes-and-casemix-collection-nocc.
- The rating period is generally the preceding two weeks for inpatients at admission (AMHCON 2014).

VALID VALUES

The following Value definitions have been sourced from the NOCC – Glossaries for NOCC Measures (AMHCON 2014):

0 – No problems within the stated period

The patient did not exhibit problems of this kind during the period rated.

1 – Minor problem requiring no action

The patient has exhibited somewhat odd or eccentric beliefs not in keeping with cultural norms.

2 – Mild problem but definitely present

Delusions or hallucinations (e.g. voices, visions) are present, but there is little distress to patient or manifestation in bizarre behaviour, that is, a present, but mild clinical problem.

3 – Moderately severe problem

The patient has a marked preoccupation with delusions or hallucinations, causing significant distress or manifested in obviously bizarre behaviour, that is, a moderately severe clinical problem.

4 – Severe to very severe problem

Mental state and behaviour is seriously and adversely affected by delusions or hallucinations, with a major impact on patient or others.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
3000	HoNOS 65+ assessment is missing	Critical
3001	HoNOS 65+ assessment is not complete	Critical
3005	HoNOS 65+ assessment score(s) is not in range	Critical

HoNOS 65+ Problems with Depressive Symptoms (on Admission)

Data element name:	HoNOS 65+ Problems with Depressive Symptoms
Definition:	A clinical measure of problems with depressive symptoms occurring in the period rated for a patient receiving psychogeriatric care.
Collection requirement:	Mandatory for Psychogeriatric Care episodes only
METeOR reference:	495880
Format:	Numeric
Maximum length:	1
Permitted values:	0 – No problems within the stated period 1 – Minor problem requiring no action 2 – Mild problem but definitely present 3 – Moderately severe problem 4 – Severe to very severe problem

GUIDE FOR USE

- A HoNOS 65+ Problems with Depressive Symptoms score:
    - Is only required where the care type is Psychogeriatric
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected at the start of a Psychogeriatric episode
    - Must be captured in accordance with the NOCC data collection requirements for the HoNOS 65+ tool that is administered by the AMHCON. These can be found at: http://amhocn.org/home/useful-resources/national-outcomes-and-casemix-collection-nocc.
- The rating period is generally the preceding two weeks for inpatients at admission (AMHCON 2014).

VALID VALUES

The following Value definitions have been sourced from the NOCC – Glossaries for NOCC Measures (AMHCON 2014):

0 – No problems within the stated period

The patient did not exhibit problems of this kind during the period rated.

1 – Minor problem requiring no action

The patient exhibited minor changes in mood only.

2 – Mild problem but definitely present

The patient exhibited mild but definite depression on subjective or objective measures (e.g. loss of interest or pleasure, lack of energy, loss of self–esteem, feelings of guilt).

3 – Moderately severe problem

The patient exhibited moderate depression on subjective or objective measures (depressive symptoms more marked).

4 – Severe to very severe problem

The patient exhibited severe depression on subjective or objective grounds (e.g. profound loss of interest or pleasure, preoccupation with ideas of guilt or worthlessness).

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
3000	HoNOS 65+ assessment is missing	Critical
3001	HoNOS 65+ assessment is not complete	Critical
3005	HoNOS 65+ assessment score(s) is not in range	Critical

HoNOS 65+ Other Mental and Behavioural Problems (on Admission)

Data element name:	HoNOS 65+ Other Mental & Behavioural Problems
Definition:	A clinical measure of other mental and behavioural problems occurring in the period rated for a patient receiving psychogeriatric care.
Collection requirement:	Mandatory for Psychogeriatric Care episodes only
METeOR reference:	495880
Format:	Numeric
Maximum length:	1
Permitted values:	0 – No problems within the stated period 1 – Minor problem requiring no action 2 – Mild problem but definitely present 3 – Moderately severe problem 4 – Severe to very severe problem

GUIDE FOR USE

- A HoNOS 65+ Other Mental & Behavioural Problems score:
    - Is only required where the care type is Psychogeriatric
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected at the start of a Psychogeriatric episode
    - Must be captured in accordance with the NOCC data collection requirements for the HoNOS 65+ tool that is administered by the AMHCON. These can be found at: http://amhocn.org/home/useful-resources/national-outcomes-and-casemix-collection-nocc.
- The rating period is generally the preceding two weeks for inpatients at admission (AMHCON 2014).

VALID VALUES

The following Value definitions have been sourced from the NOCC – Glossaries for NOCC Measures (AMHCON 2014):

0 – No problems within the stated period

The patient did not exhibit problems of this kind during the period rated.

1 – Minor problem requiring no action

The patient exhibited minor, non-clinical problems.

2 – Mild problem but definitely present

A problem is clinically present, but at a mild level. For example, the problem is intermittent and the patient maintains a degree of control or is not unduly distressed.

3 – Moderately severe problem

There is a moderately severe clinical problem. For example, more frequent, more distressing or more marked symptoms.

4 – Severe to very severe problem

There are severe, persistent problems which dominate or seriously affect most activities.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
3000	HoNOS 65+ assessment is missing	Critical
3001	HoNOS 65+ assessment is not complete	Critical
3005	HoNOS 65+ assessment score(s) is not in range	Critical

HoNOS 65+ Problems with Relationships (on Admission)

Data element name:	HoNOS 65+ Problems with Relationships
Definition:	A clinical measure of problems with social or supportive relationships occurring in the period rated for a patient receiving psychogeriatric care.
Collection requirement:	Mandatory for Psychogeriatric Care episodes only
METeOR reference:	495880
Format:	Numeric
Maximum length:	1
Permitted values:	0 – No problems within the stated period 1 – Minor problem requiring no action 2 – Mild problem but definitely present 3 – Moderately severe problem 4 – Severe to very severe problem

GUIDE FOR USE

- A HoNOS 65+ Problems with Relationships score:
    - Is only required where the care type is Psychogeriatric
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected at the start of a Psychogeriatric episode
    - Must be captured in accordance with the NOCC data collection requirements for the HoNOS 65+ tool that is administered by the AMHCON. These can be found at: http://amhocn.org/home/useful-resources/national-outcomes-and-casemix-collection-nocc.
- The rating period is generally the preceding two weeks for inpatients at admission (AMHCON 2014).

VALID VALUES

The following Value definitions have been sourced from the NOCC – Glossaries for NOCC Measures (AMHCON 2014):

0 – No problems within the stated period

The patient did not exhibit problems of this kind during the period rated.

1 – Minor problem requiring no action

The patient experiences minor, non-clinical problems.

2 – Mild problem but definitely present

The patient experiences definite problems in making, sustaining or adapting to supportive relationships (e.g. because of controlling manner, or arising out of difficult, exploitative or abusive relationships). There are definite but mild difficulties reported by patient or evident to carers or others.

3 – Moderately severe problem

The patient experiences persistent, significant problems with relationships. There are moderately severe conflicts or problems identified within the relationship by the patient or evident to carers or others.

4 – Severe to very severe problem

The patient experiences severe difficulties associated with social relationships (e.g. isolation, withdrawal, conflict, abuse) and major tensions and stresses.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
3000	HoNOS 65+ assessment is missing	Critical
3001	HoNOS 65+ assessment is not complete	Critical
3005	HoNOS 65+ assessment score(s) is not in range	Critical

HoNOS 65+ Problems with Activities of Daily Living (on Admission)

Data element name:	HoNOS 65+ Problems with Activities of Daily Living
Definition:	A clinical measure of problems with activities of daily living occurring in the period rated for a patient receiving psychogeriatric care.
Collection requirement:	Mandatory for Psychogeriatric Care episodes only
METeOR reference:	495880
Format:	Numeric
Maximum length:	1
Permitted values:	0 – No problems within the stated period 1 – Minor problem requiring no action 2 – Mild problem but definitely present 3 – Moderately severe problem 4 – Severe to very severe problem

GUIDE FOR USE

- A HoNOS 65+ Problems with Activities of Daily Living score:
    - Is only required where the care type is Psychogeriatric
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected at the start of a Psychogeriatric episode
    - Must be captured in accordance with the NOCC data collection requirements for the HoNOS 65+ tool that is administered by the AMHCON. These can be found at: http://amhocn.org/home/useful-resources/national-outcomes-and-casemix-collection-nocc.
- The rating period is generally the preceding two weeks for inpatients at admission (AMHCON 2014).

VALID VALUES

The following Value definitions have been sourced from the NOCC – Glossaries for NOCC Measures (AMHCON 2014):

0 – No problems within the stated period

The patient did not exhibit problems of this kind during the period rated. The patient had good ability to function effectively in all basic activities (e.g. continent – or able to manage incontinence appropriately, able to feed self and dress) and complex skills (e.g. driving or able to make use of transport facilities, able to handle financial affairs appropriately).

1 – Minor problem requiring no action

The patient has exhibited minor problems only without significantly adverse consequences. For example, the patient is untidy, mildly disorganised and/or there is some evidence to suggest minor difficulty with complex skills but still able to cope effectively.

2 – Mild problem but definitely present

The patient performed self–care and basic activities adequately (though some prompting may be required), but difficulty with more complex skills (e.g. problem organising and making a drink or meal, deterioration in personal interest especially outside the home situation, problems with driving, transport or financial judgements).

3 – Moderately severe problem

The patient has problems evident in one or more areas of self–care activities (e.g. needs some supervision with dressing and eating, occasional urinary incontinence or continent only if toileted) as well as inability to perform several complex skills.

4 – Severe to very severe problem

The patient has severe disability or incapacity in all or nearly all areas of basic and complex skills (e.g. full supervision required with dressing and eating, frequent urinary or faecal incontinence).

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
3000	HoNOS 65+ assessment is missing	Critical
3001	HoNOS 65+ assessment is not complete	Critical
3005	HoNOS 65+ assessment score(s) is not in range	Critical

HoNOS 65+ Problems with Living Conditions (on Admission)

Data element name:	HoNOS 65+ Problems with Living Conditions
Definition:	A clinical measure of problems with living conditions occurring in the period rated for a patient receiving psychogeriatric care.
Collection requirement:	Mandatory for Psychogeriatric Care episodes only
METeOR reference:	495880
Format:	Numeric
Maximum length:	1
Permitted values:	0 – No problems within the stated period 1 – Minor problem requiring no action 2 – Mild problem but definitely present 3 – Moderately severe problem 4 – Severe to very severe problem

GUIDE FOR USE

- A HoNOS 65+ Problems with Relationships score:
    - Is only required where the care type is Psychogeriatric
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected at the start of a Psychogeriatric episode
    - Must be captured in accordance with the NOCC data collection requirements for the HoNOS 65+ tool that is administered by the AMHCON. These can be found at: http://amhocn.org/home/useful-resources/national-outcomes-and-casemix-collection-nocc.
- The rating period is generally the preceding two weeks for inpatients at admission (AMHCON 2014).

VALID VALUES

The following Value definitions have been sourced from the NOCC – Glossaries for NOCC Measures (AMHCON 2014):

0 – No problems within the stated period

The patient did not exhibit problems of this kind during the period rated. Accommodation and living conditions are acceptable; helpful in keeping any disability rated at Scale 10 to the lowest level possible and minimising any risk, and supportive of self–help; the patient is satisfied with their accommodation.

1 – Minor problem requiring no action

Accommodation is reasonably acceptable with only minor or transient problems related primarily to the patient's preferences rather than any significant problems or risks associated with their environment (e.g. not ideal location, not preferred option, doesn't like food).

2 – Mild problem but definitely present

The patient's basic necessities are met but significant problems with one or more aspects of the accommodation or regime (e.g. lack of proper adaptation to optimise function relating for instance to stairs, lifts or other problems of access). Accommodation arrangements may be associated with risk to patient (e.g. injury) which would otherwise be reduced.

3 – Moderately severe problem

There are distressing multiple problems with accommodation. For example some basic necessities are absent (unsatisfactory or unreliable heating, lack of proper cooking facilities, inadequate sanitation). There are clear elements of risk to the patient resulting from aspects of the physical environment.

4 – Severe to very severe problem

Accommodation is unacceptable. For example, there is lack of basic necessities, insecure, or living conditions are otherwise intolerable, contributing adversely to the patient's condition or placing them at high risk of injury or other adverse consequences.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
3000	HoNOS 65+ assessment is missing	Critical
3001	HoNOS 65+ assessment is not complete	Critical
3005	HoNOS 65+ assessment score(s) is not in range	Critical

HoNOS 65+ Problems with Occupation and Activities (on Admission)

Data element name:	HoNOS 65+ Problems with Occupation and Activities
Definition:	A clinical measure of problems with occupation and activities occurring in the period rated for a patient receiving psychogeriatric care.
Collection requirement:	Mandatory for Psychogeriatric Care episodes only
METeOR reference:	495880
Format:	Numeric
Maximum length:	1
Permitted values:	0 – No problems within the stated period 1 – Minor problem requiring no action 2 – Mild problem but definitely present 3 – Moderately severe problem 4 – Severe to very severe problem

GUIDE FOR USE

- A HoNOS 65+ Problems with Occupation and Activities score:
    - Is only required where the care type is Psychogeriatric
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected at the start of a Psychogeriatric episode
    - Must be captured in accordance with the NOCC data collection requirements for the HoNOS 65+ tool that is administered by the AMHCON. These can be found at: http://amhocn.org/home/useful-resources/national-outcomes-and-casemix-collection-nocc.
- The rating period is generally the preceding two weeks for inpatients at admission (AMHCON 2014).

VALID VALUES

The following Value definitions have been sourced from the NOCC – Glossaries for NOCC Measures (AMHCON 2014):

0 – No problems within the stated period

The patient did not exhibit problems of this kind during the period rated. The patient's day-time environment is acceptable and there is disability support that maximises autonomy.

1 – Minor problem requiring no action

The patient experiences minor or temporary problems. For example, good facilities are available but not always at appropriate times for the patient.

2 – Mild problem but definitely present

The patient experiences a limited choice of activities. For example, insufficient carer or professional support or a useful day setting available but for very limited hours.

3 – Moderately severe problem

The patient experiences marked deficiency in skilled services and support available to help optimise activity level and autonomy. There is little opportunity to use skills or to develop new ones and unskilled care is difficult to access.

4 – Severe to very severe problem

The patient experiences a lack of any effective opportunity for daytime activities and this makes the patient's problems worse or the patient refuses services offered which might improve their situation.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
3000	HoNOS 65+ assessment is missing	Critical
3001	HoNOS 65+ assessment is not complete	Critical
3005	HoNOS 65+ assessment score(s) is not in range	Critical

Impairment Type (on Admission)

Data element name:	Impairment Type
Definition:	The primary impairment which is the reason for the admission to the sub-acute episode, as represented by a code.
Collection requirement:	Mandatory for Rehabilitation care episodes only
METeOR reference:	449141
Format:	Character
Maximum length:	1
Permitted values:	See *Appendix 5 – AROC Impairment Types*

GUIDE FOR USE

- The AROC impairment code set classifies the primary reason for a patient undergoing an episode of rehabilitation care.
- The code set contains the following high level impairment types:
    - Stroke
    - Brain dysfunction
    - Neurological conditions
    - Spinal cord dysfunction
    - Amputation of limb
    - Arthritis
    - Pain syndromes
    - Orthopaedic conditions
    - Cardiac
    - Pulmonary
    - Burns
    - Congenital deformities
    - Other disabling impairments
    - Major multiple trauma
    - Developmental disabilities
    - Re-conditioning/restorative
- Within each high level impairment type is a subset of codes providing more specific detail on the type of impairment. For example:
    - Stroke:
        - Left body involvement (right brain)
        - Right body involvement (left brain)
        - Bilateral involvement
        - No paresis

        - Other stroke

- An Impairment Code:

    - Is only required for Rehabilitation and GEM care types
    - It is not required where the admission is for assessment only and no further treatment or intervention was provided (Admission for Assessment Only = 1 – Yes)
    - Must be collected within 72 hours of the start of a Rehabilitation or GEM episode.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
2000	Impairment type is missing	Critical
2001	Impairment type is invalid	Critical

Palliative Care Phase Start Date

Data element name:	Palliative Care Phase Start Date
Definition:	The date on which an admitted patient commences a phase of palliative care, expressed as DDMMYYYY.
Collection requirement:	Mandatory for Palliative Care episodes only
METeOR reference:	445858
Format:	Date
Maximum length:	8
Permitted values:	DDMMYYYY

GUIDE FOR USE

- Within a given Palliative Care episode, a patient can have up to 11 different palliative care phases.
- The first Phase Start Date is equal to the associated Admission or Care Type Start Date. Subsequent Phase Start Dates are equal to the previous Phase End Date.
- Identifies the time period in which the phase of care occurred and is used in the derivation of length of phase.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
5001	Phase of care is missing start and/or end date	Critical
5002	Phase of care does not cover whole episode duration	Critical
5003	Phase of care end date does not correspond with next phase of care start date	Critical
5006	First phase of care start date is before admission date	Critical
5007	First phase of care start date is after admission date	Critical

Palliative Care Phase End Date

Data element name:	Palliative Care Phase End Date
Definition:	The date on which an admitted patient completes a phase of palliative care, expressed as DDMMYYYY.
Collection requirement:	Mandatory for Palliative Care episodes only
METeOR reference:	445598
Format:	Date
Maximum length:	8
Permitted values:	DDMMYYYY

GUIDE FOR USE

- Within a given Palliative Care episode, a patient can have up to 11 different palliative care phases.
- The Palliative Care Phase End Date is equal to the next Phase Start Date.
- The last Palliative Care End Date is equal to the Episode or Care Type End Date.
- Palliative Care Phase End Date identifies the time period in which the phase of care occurred and is used to derive length of phase.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
5001	Phase of care is missing start and/or end date	Critical
5002	Phase of care does not cover whole episode duration	Critical
5003	Phase of care end date does not correspond with next phase of care start date	Critical
5004	Last phase of care end date is after separation date	Critical
5005	Last phase of care end date is before separation date	Critical

Palliative Care Phase Type

Data element name:	Palliative Care Phase Type
Definition:	The patient's stage of illness or situation within the episode of care in terms of the recognised phases of palliative care, as represented by a code.
Collection requirement:	Mandatory for Palliative Care episodes only
METeOR reference:	445942
Format:	Character
Maximum length:	1
Permitted values:	1 – Stable 2 – Unstable 3 – Deteriorating 4 – Terminal 9 – Unknown

GUIDE FOR USE

- Palliative care phases provide a clinical indication of the type of care required and have been shown to correlate strongly with survival within longitudinal prospective studies. Within a given Palliative care episode, a patient can have up to 11 different palliative care phases.
- Palliative care phases are not sequential and a patient may move back and forth between phases.
- Palliative Care Phase Type is not mandatory for collection if Admission for Assessment Only = 1 – Yes.
- A phase record should not have the same Phase Type as the previous or next phase record within an episode.

VALID VALUES

The following Value definitions have been sourced from the AHSRI Palliative Care Outcomes Collaboration Clinical Manual (2014):

1 – Stable

The patient symptoms are adequately controlled by established management. Further interventions to maintain symptom control and quality of life have been planned. The situation of the family/carers is relatively stable and no new issues are apparent. Any needs are met by the established plan of care.

2 – Unstable

The patient experiences the development of a new unexpected problem or a rapid increase in the severity of existing problems, either of which require an urgent change in management or emergency

treatment. The family/carers experience a sudden change in their situation requiring urgent intervention by members of the multidisciplinary team.

3 – Deteriorating

The patient experiences a gradual worsening of existing symptoms or the development of new but expected problems. These require the application of specific plans of care and regular review but not urgent or emergency treatment. The family/carers experience gradually worsening distress and other difficulties, including social and practical difficulties, as a result of the illness of the person. This requires a planned support program and counselling as necessary.

4 – Terminal

Death is likely in a matter of days and no acute intervention is planned or required. The typical features of a person in this phase may include the following:

- Profoundly weak
- Essentially bed bound
- Drowsy for extended periods
- Disoriented for a time and has a severely limited attention span
- Increasingly disinterested in food and drink
- Finding it difficult to swallow medication
- This requires the use of frequent, usually daily, interventions aimed at physical, emotional and spiritual issues. The family/carers recognise that death is imminent and care is focussed on emotional and spiritual issues as a prelude to bereavement.

9 - Unknown

The phase of the illness has not been reported.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
5000	Phase of care information is missing	Critical
5008	Palliative phase of care is missing	Critical
5009	Palliative phase of care is invalid	Critical

RUG-ADL Bed Mobility

Data element name:	RUG-ADL Bed Mobility
Definition:	The Resource Utilisation Group – Activities of Daily Living score associated with assessment of an admitted patient's ability to move in bed.
Collection requirement:	Mandatory for Palliative Care and Maintenance Care episodes only
METeOR reference:	495909
Format:	Character
Maximum length:	1
Permitted values:	1 – Independent or supervision only 3 – Limited physical assistance 4 – Other than two person physical assist 5 – Two or more person physical assist

GUIDE FOR USE

- A RUG-ADL Bed Mobility score:
    - Is only required where the care type is Palliative Care or Maintenance Care
    - It is not required where the admission is for assessment only and no further treatment or intervention is provided (Admission for Assessment Only = 1 – Yes)
    - Must be captured in accordance with the RUG-ADL data collection requirements as determined by the Palliative Care Outcomes Collaboration (PCOC). These can be found in the AHSRI PCOC Clinical Manual (2014) at: http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/doc/uow129133.pdf#page=29
- A score of 2 is not valid for RUG-ADL: Bed Mobility.
- For Palliative Care episodes, a RUG-ADL score is required for each Phase of Care. Within a given Palliative Care episode, a patient can have up to 11 Phases of Care.

VALID VALUES

The following Value definitions have been sourced from the ASHRI PCOC Clinical Manual (2014):

1 – Independent or supervision only

Patient is able to readjust position in bed, and perform own pressure area relief, through spontaneous movement around bed or with prompting from carer. The patient does not require assistance and they may be independent with the use of a device.

3 – Limited physical assistance

Patient is able to readjust position in bed, and perform own pressure area relief, with the assistance of one person (AHSRI 2014).

4 – Other than two person physical assist

Patient requires the use of a hoist or other assistive device to readjust position in bed and provide pressure relief. The patient still requires the assistance of one person for task.

5 – Two or more person physical assist

Patient requires two or more assistants to readjust patient's position in bed, and perform pressure area relief.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
4000	RUG-ADL assessment is missing for maintenance episode	Critical
4001	RUG-ADL assessment score(s) is not complete	Critical
4002	RUG-ADL assessment score(s) is not in range for maintenance episode	Critical
5012	RUG-ADL assessment score(s) missing for palliative phase	Critical
5013	RUG-ADL assessment score(s) is not in range for palliative phase	Critical

RUG-ADL Toileting

Data element name:	RUG-ADL Toileting
Definition:	The Resource Utilisation Group – Activities of Daily Living score associated with assessment of an admitted patient's toileting ability.
Collection requirement:	Mandatory for Palliative Care and Maintenance Care episodes only
METeOR reference:	495909
Format:	Character
Maximum length:	1
Permitted values:	1 – Independent or supervision only 3 – Limited physical assistance 4 – Other than two person physical assist 5 – Two or more person physical assist

GUIDE FOR USE

- A RUG-ADL Bed Mobility score:
    - Is only required where the care type is Palliative Care or Maintenance Care
    - It is not required where the admission is for assessment only and no further treatment or intervention is provided (Admission for Assessment Only = 1 – Yes)
    - Must be captured in accordance with the RUG-ADL data collection requirements as determined by the Palliative Care Outcomes Collaboration (PCOC). These can be found in the AHSRI PCOC Clinical Manual (2014) at: http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/doc/uow129133.pdf#page=29
- A score of 2 is not valid for RUG-ADL: Toileting.
- For Palliative Care episodes, a RUG-ADL score is required for each Phase of Care. Within a given Palliative Care episode, a patient can have up to 11 Phases of Care.

VALID VALUES

The following Value definitions have been sourced from the ASHRI PCOC Clinical Manual (2014):

1 – Independent or supervision only

Patient is able to mobilise to toilet, adjust clothing, clean self and has no incontinence or soiling of clothing. All tasks are performed independently or with prompting from carer. The patient does not require hands-on assistance and they may be independent with the use of a device (AHSRI 2014).

3 – Limited physical assistance

Patient requires hands-on assistance of one person for one or more of the tasks (AHSRI 2014).

4 – Other than two person physical assist

Patient requires the use of a catheter/uridome/urinal and/or colostomy/bedpan/commode chair and/or insertion of enema/ suppository. The patient requires the assistance of one person for management of the device (AHSRI 2014).

5 – Two or more person physical assist

Patient requires two or more assistants to perform any step of the task (AHSRI 2014).

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
4000	RUG-ADL assessment is missing for maintenance episode	Critical
4001	RUG-ADL assessment score(s) is not complete	Critical
4002	RUG-ADL assessment score(s) is not in range for maintenance episode	Critical
5012	RUG-ADL assessment score(s) missing for palliative phase	Critical
5013	RUG-ADL assessment score(s) is not in range for palliative phase	Critical

RUG-ADL Transfers

Data element name:	RUG-ADL Transfers
Definition:	The Resource Utilisation Group – Activities of Daily Living score associated with assessment of an admitted patient's ability to transfer in and out of bed, bed to chair or in and out of shower/tub.
Collection requirement:	Mandatory for Palliative Care and Maintenance Care episodes only
METeOR reference:	495909
Format:	Character
Maximum length:	1
Permitted values:	1 – Independent or supervision only 3 – Limited physical assistance 4 – Other than two person physical assist 5 – Two or more person physical assist

GUIDE FOR USE

- A RUG-ADL Bed Mobility score:
    - Is only required where the care type is Palliative Care or Maintenance Care
    - It is not required where the admission is for assessment only and no further treatment or intervention is provided (Admission for Assessment Only = 1 – Yes)
    - Must be captured in accordance with the RUG-ADL data collection requirements as determined by the Palliative Care Outcomes Collaboration (PCOC). These can be found in the AHSRI PCOC Clinical Manual (2014) at: http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/doc/uow129133.pdf#page=29
- A score of 2 is not valid for RUG-ADL Transfers.
- For Palliative Care episodes, a RUG-ADL score is required for each Phase of Care. Within a given Palliative Care episode, a patient can have up to 11 Phases of Care.

VALID VALUES

The following Value definitions have been sourced from the ASHRI PCOC Clinical Manual (2014):

1 – Independent or supervision only

Patient is able to perform all transfers independently or with prompting of carer. The patient does not require hands-on assistance and may be independent with the use of a device.

3 – Limited physical assistance

Patient requires hands-on assistance of one person to perform any transfer during the day or night (AHSRI 2014s).

4 – Other than two person physical assist

Patient requires use of a device for any of the transfers performed during the day or night. The patient requires only one person plus a device to perform the task.

5 – Two or more person physical assist

Patient requires two or more assistants to perform any transfer during the day or night.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
4000	RUG-ADL assessment is missing for maintenance episode	Critical
4001	RUG-ADL assessment score(s) is not complete	Critical
4002	RUG-ADL assessment score(s) is not in range for maintenance episode	Critical
5012	RUG-ADL assessment score(s) missing for palliative phase	Critical
5013	RUG-ADL assessment score(s) is not in range for palliative phase	Critical

RUG-ADL Eating

Data element name:	RUG-ADL Eating
Definition:	The Resource Utilisation Group – Activities of Daily Living score associated with assessment of an admitted patient's eating ability.
Collection requirement:	Mandatory for Palliative Care and Maintenance Care episodes only
METeOR reference:	495909
Format:	Character
Maximum length:	1
Permitted values:	1 – Independent or supervision only 2 – Limited assistance 3 – Extensive assistance/total dependence/tube fed

GUIDE FOR USE

- A RUG-ADL Bed Mobility score:
    - Is only required where the care type is Palliative Care or Maintenance Care
    - It is not required where the admission is for assessment only and no further treatment or intervention is provided (Admission for Assessment Only = 1 – Yes)
    - Must be captured in accordance with the RUG-ADL data collection requirements as determined by the Palliative Care Outcomes Collaboration (PCOC). These can be found in the ASHRI PCOC Clinical Manual (2014) at: http://ahsri.uow.edu.au/content/groups/public/@web/@chsd/@pcoc/documents/doc/uow129133.pdf#page=29
- For Palliative Care episodes, a RUG-ADL score is required for each Phase of Care. Within a given Palliative Care episode, a patient can have up to 11 Phases of Care.

VALID VALUES

The following Value definitions have been sourced from the ASHRI PCOC Clinical Manual (2014):

1 – Independent or supervision only

Patient is able to cut, chew and swallow food, independently or with supervision, once meal has been presented in the customary fashion. Patient does not require hands-on assistance.

This score should be used where a patient who relies on parenteral or gastrostomy feeding is able to self-administer..

2 – Limited assistance

Patient requires hands on assistance of one person to set up or assist in bringing food to the mouth and/or requires food to be modified (soft or staged diet).

3 – Extensive assistance/total dependence/tube fed

Patient needs to be fed their meal by assistant, or does not eat or drink full meals by mouth.

This score should be used where a patient who relies on parenteral or gastrostomy feeding is unable to self-administer.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
4000	RUG-ADL assessment is missing for maintenance episode	Critical
4001	RUG-ADL assessment score(s) is not complete	Critical
4002	RUG-ADL assessment score(s) is not in range for maintenance episode	Critical
5012	RUG-ADL assessment score(s) missing for palliative phase	Critical
5013	RUG-ADL assessment score(s) is not in range for palliative phase	Critical

Type of Maintenance Care

Data element name:	Type of Maintenance Care
Definition:	The nature of the maintenance care provided to an admitted patient during an episode of care, as represented by a code.
Collection requirement:	Mandatory for Maintenance Care episodes only
METeOR reference:	496467
Format:	Character
Maximum length:	1
Permitted values:	1 – Convalescent 2 – Respite 3 – Nursing home type 5 – Other 8 – Unknown

GUIDE FOR USE

- This data element is required to be recorded for all maintenance care type episodes.
- The Type of Maintenance Care should be recorded at the start of the episode.

VALID VALUES

1 – Convalescent

Following assessment and/or treatment, the patient does not require further complex assessment or stabilisation but continues to require care over an indefinite period. Under normal circumstances the patient would be discharged but due to factors in the home environment, such as access issues or lack of available community services, the patient is unable to be discharged. Examples may include:

- Patient awaiting the completion of home modifications essential for discharge
- Patient awaiting the provision of specialised equipment essential for discharge
- Patient awaiting rehousing
- Patient awaiting supported accommodation such as hostel or group home bed
- Patient for whom community services are essential for discharge but are not yet available.

2 – Respite

An episode where the primary reason for admission is the short-term unavailability of the patient's usual care. Examples may include:

- Admission due to carer illness or fatigue
- Planned respite due to carer unavailability

- Short term closure of care facility
- Short term unavailability of community services.

3 – Nursing home type

The patient does not have a current acute care certificate and is awaiting placement in a residential aged care facility.

5 – Other

Any other reason the patient may require a maintenance episode other than those already stated.

8 – Unknown

It is not known what type of maintenance care the patient is receiving.

DATA QUALITY EDITS

Edit Number	Edit Message	Edit Severity
6000	Type of maintenance care is missing	Critical
6001	Type of maintenance care is invalid	Critical

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SECTION 9: APPENDICES

Appendix 1: SANADC Reporting Establishments List

The following hospitals are mandated to submit subacute data to the SANADC as they have wards, units or programs dedicated to the provision of subacute care:

Establishment Code	Establishment Name
0201	Albany Hospital
0203	Armadale Kelmscott District Memorial Hospital
0255	Bentley Hospital
0602	Bethesda Hospital
0208	Bunbury Hospital
0102	Fremantle Hospital and Health Service
0106	Fiona Stanely Hospital
0158	Graylands Hospital – Selby Lodge
0642	Joondalup Health Campus
0454	Kalamunda District Community Hospital
0130	Kaleeya Hospital
0629	St John of God Hospital – Mt Lawley
0239	Osborne Park Hospital
0645	Peel Health Campus
0277	Rockingham General Hospital
0101	Royal Perth Hospital
0105	Sir Charles Gairdner Hospital
0612	St John of God Hospital – Bunbury
0640	St John of God Hospital - Murdoch
0244	Swan District Hospital

Appendix 2: SANADC Designated Ward Listing

The following tables provide listings of the ward designated to provide subacute services. Please note that an asterisk next to the Ward indicates that is more than one type of subacute service is provided in that Ward.

Designated Rehabilitation Care Wards (current at 1 Jan 2015)

Establishment Code	Establishment Name	Ward(s)
0201	Albany Hospital	SUBAC – Ward E
0203	Armadale Kelmscott District Memorial Hospital	REHAB
0255	Bentley Hospital	W1 W4*
0208	Bunbury Hospital	REST
0106	Fiona Stanley Hospital	SRSB SRS1A SRS2A
0102	Fremantle Hospital and Health Service	V5 V6 B7 South
0642	Joondalup Health Campus	JHCWD0 JHCLD0 JHCBD0 JHCWL0 JHCWC1B JHCWL1 JHCWC1A JHCWA1
454	Kalamunda District Community Hospital	ANDT**
0239	Osborne Park Hospital	Ward 3* Ward 4* Ward 5*
645	Peel Health Campus	RESTORATIVE
0277	Rockingham General Hospital	ACRU*
0101	Royal Perth Hospital	3K*
0629	St John of God – Mt Lawley	MRU
0244	Swan District Hospital	REST

Designated GEM Care Wards (current at 1 Jan 2015)

Establishment Code	Establishment Name	Ward(s)
0201	Albany Hospital	SUBAC – Ward E*
0203	Armadale Kelmscott District Memorial Hospital	REHAB
0255	Bentley Hospital	W4*
0102	Fremantle Hospital and Health Service	GEM V6
0239	Osborne Park Hospital	Ward 3* Ward 4* Ward 5*
0277	Rockingham General Hospital	ACRU*
0101	Royal Perth Hospital	3K*
0105	Sir Charles Gairdner Hospital	C17

Designated Psychogeriatric Care Wards (current at 1 Jan 2015)

Establishment Code	Establishment Name	Ward(s)
0203	Armadale Kelmscott District Memorial Hospital	BANKS
0255	Bentley Hospital	W10A W10B W10C
0102	Fremantle Hospital and Health Service	W43
0239	Osborne Park Hospital	OL (Osborne Lodge)
0277	Rockingham General Hospital	MHEC MHEO
0158	Selby Lodge	PICU SELB
0629	St John of God – Mt Lawley	UFU (Ursula Frayne Unit)
0244	Swan District Hospital	MHE MHW

Designated Palliative Care Wards (current at 1 Jan 2015)

Establishment Code	Establishment Name	Ward(s)
602	Bethesda Hospital	BAY
454	Kalamunda District Community Hospital	ANDT**
612	St John of God – Bunbury	GRA
640	St John of God – Murdoch	HOS

*Combined Rehabilitation and GEM Care ward
**Combined Rehabilitation and Palliative Care Ward

Appendix 3: AN-SNAP Classification Version 3

The following section provides a descriptive listing of the Australian National Subacute and Non-acute Patient classification (Version 3).

Class	Episode Type	Description
3-101	Overnight Palliative Care	Palliative care, admit for assessment only
3-102	Overnight Palliative Care	Stable phase, RUG-ADL 4
3-103	Overnight Palliative Care	Stable phase, RUG-ADL 5-17
3-104	Overnight Palliative Care	Stable phase, RUG-ADL 18
3-105	Overnight Palliative Care	Unstable phase, RUG-ADL 4-17
3-106	Overnight Palliative Care	Unstable phase, RUG-ADL 18
3-107	Overnight Palliative Care	Deteriorating phase, RUG-ADL 4-14
3-108	Overnight Palliative Care	Deteriorating phase, RUG-ADL 15-18, age <=52
3-109	Overnight Palliative Care	Deteriorating phase, RUG-ADL 15-18, age >=53
3-110	Overnight Palliative Care	Terminal phase, RUG-ADL 4-16
3-111	Overnight Palliative Care	Terminal phase, RUG-ADL 17-18
3-112	Overnight Palliative Care	Bereavement phase
3-151	All ambulatory Palliative Care	Medical only
3-152	All ambulatory Palliative Care	Therapies only
3-153	All ambulatory Palliative Care	Stable phase, multidisciplinary
3-154	All ambulatory Palliative Care	Stable phase, nursing only, Palliative Care Problem Severity Score (PCPSS) <=6, RUG-ADL 4, age>=67
3-155	All ambulatory Palliative Care	Stable phase, nursing only, PCPSS<=6, RUG-ADL 4, age<=66
3-156	All ambulatory Palliative Care	Stable phase, nursing only, PCPSS<=6, RUG-ADL 5-18
3-157	All ambulatory Palliative Care	Stable phase, nursing only, PCPSS>=7
3-158	All ambulatory Palliative Care	Unstable phase, multidisciplinary, RUG-ADL 4, PCPSS<=7
3-159	All ambulatory Palliative Care	Unstable phase, multidisciplinary, RUG-ADL 4, PCPSS>=8
3-160	All ambulatory Palliative Care	Unstable phase, multidisciplinary, RUG-ADL 5-18
3-161	All ambulatory Palliative Care	Unstable phase, nursing only, RUG-ADL <=14, age>=60
3-162	All ambulatory Palliative Care	Unstable phase, nursing only, RUG-ADL <=14, age<=59

Class	Episode Type	Description
3-163	All ambulatory Palliative Care	Unstable phase, nursing only, RUG-ADL >=15
3-164	All ambulatory Palliative Care	Deteriorating phase, multidisciplinary, PCPSS <=6
3-165	All ambulatory Palliative Care	Deteriorating phase, multidisciplinary, PCPSS>=7, RUG<=10
3-166	All ambulatory Palliative Care	Deteriorating phase, multidisciplinary, PCPSS>=7, RUG>=11
3-167	All ambulatory Palliative Care	Deteriorating phase, nursing only, RUG-ADL 4
3-168	All ambulatory Palliative Care	Deteriorating phase, nursing only, RUG-ADL 5-18
3-169	All ambulatory Palliative Care	Terminal phase, multidisciplinary
3-170	All ambulatory Palliative Care	Terminal phase, nursing only
3-171	All ambulatory Palliative Care	Bereavement phase, age >=45
3-172	All ambulatory Palliative Care	Bereavement phase, age <=44
3-201	Overnight Rehabilitation	Rehabilitation, admit for assessment only
3-202	Overnight Rehabilitation	Brain, Neurological, Spinal & Major Multiple Trauma, FIM 13
3-203	Overnight Rehabilitation	All other impairments, FIM 13
3-204	Overnight Rehabilitation	Stroke , FIM motor 63-91, FIM cognition 20-35
3-205	Overnight Rehabilitation	Stroke , FIM motor 63-91, FIM cognition 5-19
3-206	Overnight Rehabilitation	Stroke, FIM motor 47-62, FIM cognition 16-35
3-207	Overnight Rehabilitation	Stroke, FIM motor 47-62, FIM cognition 5-15
3-208	Overnight Rehabilitation	Stroke, FIM motor 14-46, age>=75
3-209	Overnight Rehabilitation	Stroke, FIM motor 14-46, age<=74
3-210	Overnight Rehabilitation	Brain Dysfunction, FIM motor 56-91, FIM cognition 32-35
3-211	Overnight Rehabilitation	Brain Dysfunction, FIM motor 56-91, FIM cognition 24-31
3-212	Overnight Rehabilitation	Brain Dysfunction, FIM motor 56-91, FIM cognition 20-23
3-213	Overnight Rehabilitation	Brain Dysfunction, FIM motor 56-91, FIM cognition 5-19
3-214	Overnight Rehabilitation	Brain Dysfunction, FIM motor 24-55
3-215	Overnight Rehabilitation	Brain Dysfunction, FIM motor 14-23
3-216	Overnight Rehabilitation	Neurological, FIM motor 63-91
3-217	Overnight Rehabilitation	Neurological, FIM motor 49-62

Class	Episode Type	Description
3-218	Overnight Rehabilitation	Neurological, FIM motor 18-48
3-219	Overnight Rehabilitation	Neurological, FIM motor 14-17
3-220	Overnight Rehabilitation	Spinal Cord Dysfunction, FIM motor 81-91
3-221	Overnight Rehabilitation	Spinal Cord Dysfunction, FIM motor 47-80
3-222	Overnight Rehabilitation	Spinal Cord Dysfunction, FIM motor 14-46, age>=33
3-223	Overnight Rehabilitation	Spinal Cord Dysfunction, FIM motor 14-46, age<=32
3-224	Overnight Rehabilitation	Amputation of limb, FIM motor 72-91
3-225	Overnight Rehabilitation	Amputation of limb, FIM motor 14-71
3-226	Overnight Rehabilitation	Pain Syndromes
3-227	Overnight Rehabilitation	Orthopaedic conditions, fractures, FIM motor 58-91
3-228	Overnight Rehabilitation	Orthopaedic conditions, fractures, FIM motor 48-57
3-229	Overnight Rehabilitation	Orthopaedic conditions, fractures, FIM motor 14-47, FIM cognition 19-35
3-230	Overnight Rehabilitation	Orthopaedic conditions, fractures, FIM motor 14-47, FIM cognition 5-18
3-231	Overnight Rehabilitation	Orthopaedic conditions, replacement, FIM motor 72-91
3-232	Overnight Rehabilitation	Orthopaedic conditions, replacement, FIM motor 49-71
3-233	Overnight Rehabilitation	Orthopaedic conditions, replacement, FIM motor 14-48
3-234	Overnight Rehabilitation	Orthopaedic conditions, all other, FIM motor 68-91
3-235	Overnight Rehabilitation	Orthopaedic conditions, all other, FIM motor 53-67
3-236	Overnight Rehabilitation	Orthopaedic conditions, all other, FIM motor 14-52
3-237	Overnight Rehabilitation	Cardiac
3-238	Overnight Rehabilitation	Major Multiple Trauma, FIM total 101-126
3-239	Overnight Rehabilitation	Major Multiple Trauma, FIM total 74-100 or Burns
3-240	Overnight Rehabilitation	Major Multiple Trauma, FIM total 44-73
3-241	Overnight Rehabilitation	Major Multiple Trauma, FIM total 19-43
3-242	Overnight Rehabilitation	All other impairments, FIM motor 67-91
3-243	Overnight Rehabilitation	All other impairments, FIM motor 53-66
3-244	Overnight Rehabilitation	All other impairments, FIM motor 25-52

Class	Episode Type	Description
3-245	Overnight Rehabilitation	All other impairments, FIM motor 14-24
3-251	Same Day Rehabilitation	Brain, Major Multiple Trauma & Pulmonary
3-252	Same Day Rehabilitation	Burns, Cardiac, Pain, Spine, & Neurological
3-253	Same Day Rehabilitation	All other impairments
3-254	Outpatient & Community Rehabilitation	Outpatient and community rehabilitation, medical assessment only
3-255	Outpatient & Community Rehabilitation	Outpatient and community rehabilitation, multidisciplinary assessment
3-256	Outpatient & Community Rehabilitation	Outpatient and community rehabilitation, medical treatment only
3-257	Outpatient & Community Rehabilitation	Amputation
3-258	Outpatient & Community Rehabilitation	Brain Injury and Major Multiple Trauma
3-259	Outpatient & Community Rehabilitation	Spinal Injury
3-260	Outpatient & Community Rehabilitation	Stroke and Development Disability, sole practitioner
3-261	Outpatient & Community Rehabilitation	Stroke and Development Disability, multidisciplinary, FIM motor <=80
3-262	Outpatient & Community Rehabilitation	Stroke and Development Disability, multidisciplinary, FIM motor >=81
3-263	Outpatient & Community Rehabilitation	All other impairments, sole practitioner
3-264	Outpatient & Community Rehabilitation	All other impairments, multidisciplinary, FIM motor <=80
3-265	Outpatient & Community Rehabilitation	All other impairments, multidisciplinary, FIM motor >=81
3-301	Overnight Psychogeriatric	Psychogeriatric , admit for assessment only
3-302	Overnight Psychogeriatric	HoNOS 65+ Overactive behaviour 3,4
3-303	Overnight Psychogeriatric	HoNOS 65+ Overactive behaviour 1,2 HoNOS 65+ ADL 4
3-304	Overnight Psychogeriatric	HoNOS 65+ Overactive behaviour 1,2 HoNOS 65+ ADL 0-3
3-305	Overnight Psychogeriatric	HoNOS 65+ Overactive behaviour 0 HoNOS 65+ total>=18
3-306	Overnight Psychogeriatric	HoNOS 65+ Overactive behaviour 0 HoNOS 65+ total<=17
3-307	Overnight Psychogeriatric	Long term care

Class	Episode Type	Description
3-351	Outpatient Psychogeriatric	Outpatient psychogeriatric assessment only
3-352	Community Psychogeriatric	Assessment Only
3-353	All ambulatory Psychogeriatric	Treatment, Focus of Care=acute
3-354	All ambulatory Psychogeriatric	Treatment, Focus of Care=not acute, HoNOS 65+ total <=8
3-355	All ambulatory Psychogeriatric	Treatment, Focus of Care=not acute, HoNOS 65+ total 9-13
3-356	All ambulatory Psychogeriatric	Treatment, Focus of Care=not acute, HoNOS 65+ total >=14, HoNOS 65+ Overactive 0,1
3-357	All ambulatory Psychogeriatric	Treatment, Focus of Care=not acute, HoNOS 65+ total >=14, HoNOS 65+ Overactive 2,3,4
3-401	Overnight GEM	GEM admit for assessment only
3-402	Overnight GEM	FIM cognition <=15, FIM motor 13-43
3-403	Overnight GEM	FIM cognition <=15, FIM motor 44-91, age>=84
3-404	Overnight GEM	FIM cognition <=15, FIM motor 44-91, age<=83
3-405	Overnight GEM	FIM cognition 16-35, FIM motor 13-50
3-406	Overnight GEM	FIM cognition 16-35, FIM motor 51-77
3-407	Overnight GEM	FIM cognition 16-35, FIM motor 78-91
3-451	Same Day GEM	Same day GEM, assessment Only
3-452	Outpatients & Community GEM	Outpatient and community GEM, medical assessment only
3-453	Outpatients & Community GEM	Outpatient and community GEM, multidisciplinary assessment
3-454	Same Day GEM	All same day admitted GEM
3-455	Outpatients & Community GEM	FIM motor <=40
3-456	Outpatients & Community GEM	FIM motor 41-56
3-457	Outpatients & Community GEM	FIM motor>=57, sole practitioner
3-458	Outpatients & Community GEM	FIM motor>=57, multidisciplinary
3-501	Overnight Maintenance	Respite, RUG-ADL 15-18
3-502	Overnight Maintenance	Respite, RUG-ADL 5-14
3-503	Overnight Maintenance	Respite, RUG-ADL 4
3-504	Overnight Maintenance	Nursing Home Type, RUG-ADL 11-18

Class	Episode Type	Description
3-505	Overnight Maintenance	Nursing Home Type, RUG-ADL 4-10
3-506	Overnight Maintenance	Convalescent care
3-507	Overnight Maintenance	Other maintenance, RUG-ADL 14-18
3-508	Overnight Maintenance	Other maintenance, RUG-ADL 4-13
3-509	Overnight Maintenance	Long term care, RUG-ADL 17-18
3-510	Overnight Maintenance	Long term care, RUG-ADL 10-16
3-511	Overnight Maintenance	Long term care, RUG-ADL 4-9
3-551	All ambulatory Maintenance	Medical only
3-552	All ambulatory Maintenance	Ambulatory maintenance, nursing assessment only
3-553	All ambulatory Maintenance	Ambulatory maintenance, psychosocial assessment
3-554	All ambulatory Maintenance	Ambulatory maintenance, physical therapy assessment
3-555	Same Day & Community Maintenance	Same day and community maintenance, multidisciplinary
3-556	Outpatient Maintenance	Outpatient maintenance, multidisciplinary assessment
3-557	All ambulatory Maintenance	Maintenance and support, nursing, age>=37, RUG-ADL>=5
3-558	All ambulatory Maintenance	Maintenance and support, nursing, age>=37, RUG-ADL 4
3-559	All ambulatory Maintenance	Maintenance and support, nursing, age<=36, RUG-ADL>=5
3-560	All ambulatory Maintenance	Maintenance and support, nursing, age<=36, RUG-ADL 4
3-561	All ambulatory Maintenance	Maintenance and support, physical therapy, RUG-ADL>=6
3-562	All ambulatory Maintenance	Maintenance and support, physical therapy, RUG-ADL 4,5
3-563	Community Maintenance	Community maintenance and support, multidisciplinary, age>=27, RUG-ADL 4-11
3-564	All ambulatory Maintenance	Maintenance and support, multidisciplinary, age>=27, RUG-ADL>=12
3-565	Outpatient Maintenance	Outpatient maintenance and support, multidisciplinary, age>=27, RUG-ADL 4-11
3-566	All ambulatory Maintenance	Maintenance and support, multidisciplinary, <=26 yrs
Error classes		
3-901	Overnight Palliative Care ungroupable	Data error - ungroupable

Class	Episode Type	Description
3-902	Overnight Rehabilitation ungroupable	Data error - ungroupable
3-903	Overnight GEM ungroupable	Data error - ungroupable
3-904	Overnight Psychogeriatric ungroupable	Data error - ungroupable
3-905	Overnight Maintenance ungroupable	Data error - ungroupable
3-906	All other subacute care ungroupable	Data error - ungroupable

Appendix 4: Subacute/Non-acute Care ABF Technical Specifications for Submission of Data (2014/2015)

Data Element Number	Data Element	Format	Length	Position
Patient/Separation Identifying Information				
1	Account/Admission Number	Alphanumeric	12	1
2	Patient Identifier - UMRN	Alphanumeric	10	13
3	Admission Date	DDMMYYYY - Zero Filled	8	23
4	Separation Date	DDMMYYYY - Zero Filled	8	31
5	Establishment	Numeric	4	39
Care Type = Rehab				
6	Assessment Date	DDMMYYYY - Zero Filled	8	43
7	Admission for Assessment Only	Numeric	1	51
8	Impairment Type	NN.NNNN	7	52
9	FIM - Eating (on Admission)	Numeric	1	59
10	FIM - Grooming (on Admission)	Numeric	1	60
11	FIM - Bathing (on Admission)	Numeric	1	61
12	FIM - Dressing Upper Body (on Admission)	Numeric	1	62
13	FIM - Dressing Lower Body (on Admission)	Numeric	1	63
14	FIM - Toileting (on Admission)	Numeric	1	64
15	FIM - Bladder Management (on Admission)	Numeric	1	65
16	FIM - Bowel Management (on Admission)	Numeric	1	66
17	FIM - Transfer To Bed/Chair (on Admission)	Numeric	1	67
18	FIM - Transfer To Toilet (on Admission)	Numeric	1	68
19	FIM - Transfer To Shower/Bath (on Admission)	Numeric	1	69
20	FIM - Locomotion (on Admission)	Numeric	1	70
21	FIM - Stairs (on Admission)	Numeric	1	71
22	FIM - Comprehension (on Admission)	Numeric	1	72
23	FIM - Expression (on Admission)	Numeric	1	73
24	FIM - Social Interaction (on Admission)	Numeric	1	74
25	FIM - Problem Solving (on Admission)	Numeric	1	75
26	FIM - Memory (on Admission)	Numeric	1	76
Care Type = Geriatric Evaluation and Management				

Data Element Number	Data Element	Format	Length	Position
6	Assessment Date	DDMMYYYY - Zero Filled	8	43
7	Admission for Assessment Only	Numeric	1	51
8	Impairment Type	NN.NNNN	7	52
9	FIM - Eating (on Admission)	Numeric	1	59
10	FIM - Grooming (on Admission)	Numeric	1	60
11	FIM - Bathing (on Admission)	Numeric	1	61
12	FIM - Dressing Upper Body (on Admission)	Numeric	1	62
13	FIM - Dressing Lower Body (on Admission)	Numeric	1	63
14	FIM - Toileting (on Admission)	Numeric	1	64
15	FIM - Bladder Management (on Admission)	Numeric	1	65
16	FIM - Bowel Management (on Admission)	Numeric	1	66
17	FIM - Transfer To Bed/Chair (on Admission)	Numeric	1	67
18	FIM - Transfer To Toilet (on Admission)	Numeric	1	68
19	FIM - Transfer To Shower/Bath (on Admission)	Numeric	1	69
20	FIM - Locomotion (on Admission)	Numeric	1	70
21	FIM - Stairs (on Admission)	Numeric	1	71
22	FIM - Comprehension (on Admission)	Numeric	1	72
23	FIM - Expression (on Admission)	Numeric	1	73
24	FIM - Social Interaction (on Admission)	Numeric	1	74
25	FIM - Problem Solving (on Admission)	Numeric	1	75
26	FIM - Memory (on Admission)	Numeric	1	76
Care Type = Psychogeriatric				
6	Assessment Date	DDMMYYYY - Zero Filled	8	43
7	Admission for Assessment Only	Numeric	1	51
27	HoNOS 65+ - Behavioural Disturbance (on Admission)	Numeric	1	52
28	HoNOS 65+ - Non-accidental Self Injury (on Admission)	Numeric	1	53
29	HoNOS 65+ - Problem Drinking or Drug Taking (on Admission)	Numeric	1	54
30	HoNOS 65+ - Cognitive Problems (on Admission)	Numeric	1	55
31	HoNOS 65+ - Physical Illness or Disability Problems (on Admission)	Numeric	1	56
32	HoNOS 65+ - Problems Associated with Hallucinations & Delusions (on Admission)	Numeric	1	57

Data Element Number	Data Element	Format	Length	Position
33	HoNOS 65+ - Problems with Depressive Symptoms (on Admission)	Numeric	1	58
34	HoNOS 65+ - Other Mental & Behavioural Problems (on Admission)	Numeric	1	59
35	HoNOS 65+ - Problems with Relationships (on Admission)	Numeric	1	60
36	HoNOS 65+ - Problems with Activities of Daily Living (on Admission)	Numeric	1	61
37	HoNOS 65+ - Problems with Living Conditions (on Admission)	Numeric	1	62
38	HoNOS 65+ - Problems with Occupation & Activities (on Admission)	Numeric	1	63
Care Type = Palliative				
***Allow for up to eleven palliative phase entries for each Palliative admission.**				
7	Admission for Assessment Only	Numeric	1	51
All variables required for each Phase				
39	Palliative Phase Start Date	DDMMYYYY - Zero Filled	8	89
40	Palliative Phase End Date	DDMMYYYY - Zero Filled	8	Complete each phase as a 29 character string. i.e. Phase 1 = 89-117
41	Assessment Date	DDMMYYYY - Zero Filled	8	
42	Palliative Care Phase Type	Numeric	1	
43	RUG-ADL - Bed Mobility	Numeric	1	
44	RUG-ADL - Toileting	Numeric	1	
45	RUG-ADL - Transfers	Numeric	1	
46	RUG-ADL - Eating	Numeric	1	
Care Type = Maintenance				
6	Assessment Date	DDMMYYYY - Zero Filled	8	43
47	Type of Maintenance Care	Numeric	1	408
43	RUG-ADL - Bed Mobility	Numeric	1	409
44	RUG-ADL - Toileting	Numeric	1	410
45	RUG-ADL - Transfers	Numeric	1	411
46	RUG-ADL - Eating	Numeric	1	412
Data Entry Variables - All Care Types				
52	Record Creation Date	DDMMYYYY - Zero Filled	8	413
53	Last Amended Date	DDMMYYYY - Zero Filled	8	421
54	Last Amended HE Number	Alphanumeric	50	429

Appendix 5: AROC Impairment Types (Australian Version 2, effective July 2012)

The Australasian Rehabilitation Outcomes Centre (AROC) is a national body that collects and reports data on the specialist medical rehabilitation sector. Data collected for AROC is primarily used to develop a national benchmarking system to improve clinical rehabilitation outcomes, produce information on the efficacy of interventions and develop clinical and management information based on functional outcomes and impairment groupings.

The AROC Impairment Codes (as specified below) provide the list of acceptable values for capture of the subacute data element known as Impairment Type.

V4 dataset — AROC IMPAIRMENT CODES (AUS Version 02)	
Code	**Name**
STROKE	
Stroke - haemorrhagic	
1.11	Left Body Involvement (Right Brain)
1.12	Right Body Involvement (Left Brain)
1.13	Bilateral Involvement
1.14	No Paresis
1.19	Other stroke
Stroke - ischaemic	
1.21	Left Body Involvement (Right Brain)
1.22	Right Body Involvement (Left Brain)
1.23	Bilateral Involvement
1.24	No Paresis
1.29	Other stroke
BRAIN DYSFUNCTION	
Non-traumatic brain dysfunction	
2.11	Non traumatic subarachnoid haemorrhage
2.12	Anoxic brain damage
2.13	Other non-traumatic brain dysfunction
Traumatic brain dysfunction	
2.21	Traumatic, open injury
2.22	Traumatic, closed injury
NEUROLOGICAL CONDITIONS	
3.1	Multiple sclerosis
3.2	Parkinsonism
3.3	Polyneuropathy
3.4	Guillain-Barre
3.5	Cerebral palsy
3.8	Neuromuscular disorders
3.9	Other neurologic
SPINAL CORD DYSFUNCTION	
Non-traumatic spinal cord dysfunction	

V4 dataset — AROC IMPAIRMENT CODES (AUS Version 02)	
Code	**Name**
4.111	Paraplegia, incomplete
4.112	Paraplegia, complete
4.1211	Quadriplegia incomplete C1-4
4.1212	Quadriplegia incomplete C5-8
4.1221	Quadriplegia complete C1-4
4.1222	Quadriplegia complete C5-8
4.13	Other non-traumatic spinal cord dysfunction
Traumatic spinal cord dysfunction	
4.211	Paraplegia, incomplete
4.212	Paraplegia, complete
4.2211	Quadriplegia incomplete C1-4
4.2212	Quadriplegia incomplete C5-8
4.2221	Quadriplegia complete C1-4
4.2222	Quadriplegia complete C5-8
4.23	Other traumatic spinal cord dysfunction
AMPUTATION OF LIMB	
Amputation of limb NOT resulting from a trauma	
5.11	Single upper amputation above the elbow
5.12	Single upper amputation below the elbow
5.13	Single lower amputation above the knee
5.14	Single lower amputation below the knee
5.15	Double lower amputation above the knee
5.16	Double lower amputation above/below the knee
5.17	Double lower amputation below the knee
5.18	Partial foot amputation (includes single/double)
5.19	Other amputation
Amputation of limb as a result of trauma	
5.21	Single upper amputation above the elbow
5.22	Single upper amputation below the elbow
5.23	Single lower amputation above the knee
5.24	Single lower amputation below the knee
5.25	Double lower amputation above the knee
5.26	Double lower amputation above/below the knee
5.27	Double lower amputation below the knee
5.28	Partial foot amputation (includes single/double)
5.29	Other amputation
ARTHRITIS	
6.1	Rheumatoid arthritis
6.2	Osteoarthritis
6.9	Other arthritis
PAIN SYNDROMES	
7.1	Neck pain

V4 dataset — AROC IMPAIRMENT CODES (AUS Version 02)	
Code	**Name**
7.2	Back pain
7.3	Extremity pain
7.4	Headache (includes migraine)
7.5	Multi-site pain
7.9	Other pain
ORTHOPAEDIC CONDITIONS	
Fracture	
8.111	Fracture of hip, unilateral (includes #NOF)
8.112	Fracture of hip, bilateral (includes #NOF)
8.12	Fracture of shaft of femur (excludes femur involving knee joint)
8.13	Fracture of pelvis
8.141	Fracture of knee (includes patella, femur involving knee joint, tibia or fibula involving knee joint)
8.142	Fracture of leg, ankle, foot
8.15	Fracture of upper limb (includes hand, fingers, wrist, forearm, arm, shoulder)
8.16	Fracture of spine (excludes where the major disorder is pain)
8.17	Fracture of multiple sites
8.19	Other orthopaedic fracture
Post orthopaedic surgery	
8.211	Unilateral hip replacement
8.212	Bilateral hip replacement
8.221	Unilateral knee replacement
8.222	Bilateral knee replacement
8.231	Knee and hip replacement same side
8.232	Knee and hip replacement different sides
8.24	Shoulder replacement or repair
8.25	Post spinal surgery
8.26	Other orthopaedic surgery
Soft tissue injury	
8.3	Soft tissue injury
CARDIAC	
9.1	Following recent onset of new cardiac impairment
9.2	Chronic cardiac insufficiency
9.3	Heart or heart/lung transplant
PULMONARY	
10.1	Chronic obstructive pulmonary disease
10.2	Lung transplant
10.9	Other pulmonary
BURNS	
11	Burns
CONGENITAL DEFORMITIES	
12.1	Spina bifida

V4 dataset — AROC IMPAIRMENT CODES (AUS Version 02)	
Code	**Name**
12.9	Other congenital
OTHER DISABLING IMPAIRMENTS	
13.1	Lymphoedema
13.3	Conversion disorder
13.9	Other disabling impairments. This classification should rarely be used.
MAJOR MULTIPLE TRAUMA	
14.1	Brain + spinal cord injury
14.2	Brain + multiple fracture/amputation
14.3	Spinal cord + multiple fracture/amputation
14.9	Other multiple trauma
DEVELOPMENTAL DISABILITIES	
15.1	Developmental disabilities
RE-CONDITIONING/RESTORATIVE	
16.1	Re-conditioning following surgery
16.2	Re-conditioning following medical illness
16.3	Cancer rehabilitation

Appendix 6: SANADC Data Quality Edits

The following section provides a descriptive listing of the SANADC Data Quality Edits that are currently active. The following table provides definitions on how to interpret edit documentation:

Edit Number	*A unique number assigned to each edit. The edits are classified into series based on the specific subacute measure or data item:* *1XXX FIM* *2XXX Impairment Type* *3XXX HoNOS 65+* *4XXX RUG-ADL* *5XXX Phase of Care* *6XXX Maintenance* *9XXX Other* *The Edit Number will appear on the Data Quality Error Report.*
Edit Name	*The name of the edit. This will appear on the Data Quality Error Report.*
Effect	*The edit effect indicates the impact and severity of an error on reporting and subsequent funding of an episode. It also guides data collectors on how they should handle and prioritise their edit correction to ensure maximum reporting and funding. There are two types of effect:* *Critical:* *Record is in error and cannot reported and funded as long as the error exists. Records in critical error must be corrected and resubmitted to SANADC.* *Warning:* *Record is in error or there has been some information provided that is unusual or inconsistent with other data items. The record can be reported and funded in its current state, however there may be some information within the record that is unusual or inconsistent. To address, users should work through the edit logic and check all applicable fields and correct any errors or verify the reported information as true and correct.*
Care Type(s)	*The care types that are applicable to this edit.*
Description	*A brief description of why the edit has triggered.*
Logic	*This specifies the working logic for how the edit is triggered. It is useful in highlighting the applicable data items that should be checked when correcting an edit.*

Edit Number	1000
Edit Name	FIM assessment is missing
Effect	Critical
Care Type(s)	Rehabilitation; GEM
Description	The subacute episode is missing the FIM Assessment Date and all FIM Assessment Scores.
Logic	IF Assessment Date (Data Item 6) AND FIM Assessment Score(s) (Data Items 9 – 26) are all blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 1000

Edit Number	1001
Edit Name	FIM assessment is not complete
Effect	Critical
Care Type(s)	Rehabilitation; GEM
Description	The subacute episode is missing one or more FIM assessment scores.
Logic	IF at least one FIM Assessment Score(s) (Data Items 9 – 26) is blank. AND Admission for Assessment Only ≠ 1 AND Assessment Date (Data Item 6) AND FIM Assessment Score(s) (Data Items 9 – 26) are not all blank THEN trigger Edit 1001

Edit Number	1002
Edit Name	FIM assessment date is missing
Effect	Critical
Care Type(s)	Rehabilitation; GEM
Description	The subacute episode is missing the FIM Assessment Date however FIM Assessment Scores and/or Impairment Code information has been recorded.
Logic	IF Assessment Date (Data Item 6) is blank AND Admission for Assessment Only ≠ 1 AND Assessment Date (Data Item 6) AND FIM Assessment Score(s) (Data Items 9 – 26) are not all blank THEN trigger Edit 1002

Edit Number	1003
Edit Name	FIM assessment date is prior to admission date
Effect	Critical

Care Type(s)	Rehabilitation; GEM
Description	The FIM Assessment Date recorded is prior to the Admission Date.
Logic	IF FIM Assessment Date (Data Item 6) < Admission Date (Data Item 3) AND Assessment Date (Data Item 6) is not blank AND Assessment Date (Data Item 6) AND FIM Assessment Score(s) (Data Items 9 – 26) are not all blank THEN trigger Edit 1003

Edit Number	1004
Edit Name	FIM assessment date is after separation date
Effect	Critical
Care Type(s)	Rehabilitation; GEM
Description	The FIM Assessment Date recorded is after the Separation Date.
Logic	IF FIM Assessment Date (Data Item 6) > Separation Date (Data Item 4) AND Assessment Date (Data Item 6) is not blank AND Assessment Date (Data Item 6) AND FIM Assessment Score(s) (Data Items 9 – 26) are not all blank THEN trigger Edit 1004

Edit Number	1005
Edit Name	FIM assessment is not within 72 hours of the start of the episode of care
Effect	Critical
Care Type(s)	Rehabilitation; GEM
Description	The FIM Assessment Date recorded is at least 72 hours after the Admission Date. Please correct or verify that FIM Assessment Date has been reported accurately.
Logic	IF FIM Assessment Date (Data Item 6) > 72 hours after the Admission Date (Data Item 3) AND Assessment Date (Data Item 6) AND FIM Assessment Score(s) (Data Items 9 – 26) are not all blank THEN trigger Edit 1005

Edit Number	1006
Edit Name	FIM assessment score(s) is not in range
Effect	Critical
Care Type(s)	Rehabilitation; GEM
Description	One or more of the FIM Assessment Scores recorded is not a valid score.

	Refer to the relevant Data Definition for permitted values.
Logic	IF FIM Assessment Score(s) (Data Item 9 – 26) ≠ 1, 2, 3, 4, 5, 6 or 7 AND Admission for Assessment Only ≠ 1 AND Assessment Date (Data Item 6) AND FIM Assessment Score(s) (Data Items 9 – 26) are not all blank THEN trigger Edit 1006

Edit Number	2000
Edit Name	Impairment Type is missing
Effect	Critical
Care Type(s)	Rehabilitation
Description	The rehabilitation episode does not have a valid Impairment Code recorded. Refer to *Appendix 5: AROC Impairment Types* for permitted values.
Logic	IF Impairment Type (Data Item 8) is blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 2000

Edit Number	2001
Edit Name	Impairment Type is invalid
Effect	Critical
Care Type(s)	Rehabilitation
Description	The rehabilitation episode has an invalid value recorded for Impairment Types. Refer to *Appendix 5: AROC Impairment Types* for permitted values.
Logic	IF Impairment Type (Data item 8) ≠ valid value in *Appendix 5: AROC Impairment Type* AND Impairment Type (Data Item 8) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 2001

Edit Number	3000
Edit Name	HoNOS 65+ assessment is missing
Effect	Critical
Care Type(s)	Psychogeriatric
Description	The psychogeriatric episode is missing the HoNOS 65+ Assessment Date and all HoNOS 65+ Assessment Scores.
Logic	IF HoNOS 65+ Assessment Date (Data Item 6) AND HoNOS 65+ Assessment Scores (Data Items 27 – 38) are all blank

	AND Admission for Assessment Only ≠ 1 THEN trigger Edit 3000

Edit Number	3001
Edit Name	HoNOS 65+ assessment is not complete
Effect	Critical
Care Type(s)	Psychogeriatric
Description	The psychogeriatric episode has a HoNOS 65+ Assessment Data record but it is missing one or more HoNOS 65+ Assessment Scores.
Logic	IF at least one of HoNOS 65+ Assessment Date (Data Item 6) is blank AND Admission for Assessment Only ≠ 1 AND HoNOS 65+ Assessment Date (Data Item 6) AND HoNOS 65+ Assessment Scores (Data Items 27 – 38) are not all blank THEN trigger Edit 3001

Edit Number	3002
Edit Name	HoNOS 65+ assessment date is missing
Effect	Critical
Care Type(s)	Psychogeriatric
Description	The psychogeriatric episode has HoNOS 65+ Assessment Scores recorded but the HoNOS 65+ Assessment Date is missing.
Logic	IF HoNOS 65+ Assessment Date (Data Item 6) is blank AND Admission for Assessment Only ≠ 1 AND HoNOS 65+ Assessment Date (Data Item 6) AND HoNOS65+ Assessment Scores (Data Items 27 – 38) are not all blank THEN trigger Edit 3002

Edit Number	3003
Edit Name	HoNOS 65+ assessment date is prior to admission date
Effect	Critical
Care Type(s)	Psychogeriatric
Description	The HoNOS 65+ Assessment Date is before the Admission Date.
Logic	IF HoNOS 65+ Assessment Date (Data Item 6) < Admission Date (Data Item 3) AND HoNOS 65+ Assessment Date (Data Item 6) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 3003

Edit Number	3004
Edit Name	HoNOS 65+ assessment date is after separation date
Effect	Critical
Care Type(s)	Psychogeriatric
Description	The HoNOS 65+ Assessment Date is after the separation date.
Logic	IF HoNOS 65+ Assessment Date (Data Item 6) > Separation Date (Data Item 4) AND HoNOS 65+ Assessment Date (Data Item 6) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 3004

Edit Number	3005
Edit Name	HoNOS65+ assessment score(s) is not in range
Effect	Critical
Care Type(s)	Psychogeriatric
Description	One or more of the HoNOS 65+ Assessment Scores recorded is not a valid score. Refer to the relevant Data Definition for permitted values.
Logic	IF HoNOS 65+ Assessment Score(s) (Data Item 27 – 38) ≠ 0, 1, 2, 3 or 4 AND Admission for Assessment Only ≠ 1 AND HoNOS 65+ Assessment Date (Data Item 6) AND HoNOS 65+ Assessment Scores (Data Items 27 – 38) are not all blank THEN trigger Edit 3005

Edit Number	4000
Edit Name	RUG-ADL assessment is missing for maintenance episode
Effect	Critical
Care Type(s)	Maintenance
Description	The maintenance episode is missing the RUG-ADL Assessment Data, RUG-ADL Assessment Scores and Type of Maintenance.
Logic	IF RUG-ADL Assessment Date (Data Item 6) AND RUG-ADL Assessment Scores (Data Item 48 – 51) are all blank THEN trigger edit 4000

Edit Number	4001
Edit Name	RUG-ADL assessment score(s) is not complete
Effect	Critical

Care Type(s)	Maintenance
Description	The maintenance episode has the RUG-ADL Assessment Date and/or the Type of Maintenance Care record but is missing one or more RUG-ADL Assessment Scores.
Logic	IF at least one RUG-ADL Assessment Score(s) (Data Items 48 – 51) is blank AND RUG-ADL Assessment Date (Data Item 6) AND RUG-ADL Assessment Scores (Data Item 48 – 51) are not all blank THEN trigger Edit 4001

Edit Number	4002
Edit Name	RUG-ADL assessment score(s) is not in range for maintenance episode
Effect	Critical
Care Type(s)	Maintenance
Description	One or more of the RUG-ADL Assessment Scores recorded is not a valid score. Refer to the relevant Data Definition for permitted values.
Logic	IF RUG-ADL Assessment Score(s) (Data Item 48 – 50) ≠ 1, 3, 4 or 5 OR RUG-ADL Assessment Score (Data Item 51) ≠ 1, 2 or 3 AND RUG-ADL Assessment Date (Data Item 6) AND RUG-ADL Assessment Scores (Data Item 48 – 51) are not all blank THEN trigger Edit 4002

Edit Number	4003
Edit Name	RUG-ADL assessment date is missing for maintenance episode
Effect	Critical
Care Type(s)	Maintenance
Description	The maintenance episode has RUG-ADL Assessment Scores recorded but the RUG-ADL Assessment Date is missing.
Logic	AND RUG-ADL Assessment Date (Data Item 6) is blank AND RUG-ADL Assessment Date (Data Item 6) AND RUG-ADL Assessment Scores (Data Item 48 – 51) are not all blank THEN trigger Edit 4003

Edit Number	4004
Edit Name	RUG-ADL assessment date is prior to admission date for maintenance episode
Effect	Critical
Care Type(s)	Maintenance
Description	The RUG-ADL Assessment Date is before the Admission Date.

Logic	IF RUG-ADL Assessment Date (Data Item 6) is > Admission Date (Data Item 3) AND RUG-ADL Assessment Date (Data Item 6) is not blank THEN trigger Edit 4004

Edit Number	4005
Edit Name	RUG-ADL assessment date is after the separation date for maintenance episode
Effect	Critical
Care Type(s)	Maintenance
Description	The RUG-ADL Assessment Date is after the Separation Date.
Logic	IF RUG-ADL Assessment Date (Data Item 6) is > Admission Date (Data Item 4) AND RUG-ADL Assessment Date (Data Item 6) is not blank THEN trigger Edit 4005

Edit Number	5000
Edit Name	Phase of care information is missing
Effect	Critical
Care Type(s)	Palliative Care
Description	The palliative care episode does not have any Phase of Care information recorded.
Logic	IF Phase of Care Start Dates 1 – 11 (Data Item 39) AND Phase of Care End Dates 1 – 11 (Data Item 40) AND Assessment Dates 1 – 11 (Data Item 42) AND Palliative Care Phase Types 1 – 11 (Data Item 42) AND RUG-ADL Assessment Scores 1 – 11 (Data Item 43 – 46) are all blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5000

Edit Number	5001
Edit Name	Phase of care is missing start and/or end date
Effect	Critical
Care Type(s)	Palliative Care
Description	The Phase of Care Start Date or Phase of Care End Date for one or more phases of care is missing.
Logic	IF Phase of Care Start Date (Data Item 39) OR Phase of Care End Date (Data Item 40) is blank

	AND Phase of Care Start Dates 1 – 11 (Data Item 39) AND Phase of Care End Dates 1 – 11 (Data Item 40) AND Assessment Dates 1 – 11 (Data Item 42) AND Palliative Care Phase Types 1 – 11 (Data Item 42) AND RUG-ADL Assessment Scores 1 – 11 (Data Item 43 – 46) are not all blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5001

Edit Number	5002
Edit Name	Phase of care does not cover whole episode duration
Effect	Critical
Care Type(s)	Palliative Care
Description	The Phase of Care Start Date for the first phase of care or the Phase of Care End Date for the last phase of care does not correspond with the Admission and Separation dates for the palliative care episode.
Logic	IF Phase of Care Start Date 1 (Data Item 39) ≠ palliative Admission Date (Data Item 3) OR Phase of Care End Date 1 – 11 (Data Item 40) ≠ palliative Separation Date (Data Item 4) OR Phase of Care End Date 1 (Data Item 40) ≠ Phase of Care Start Date 2 (Data Item 39) OR Phase of Care End Date 2 (Data Item 40) ≠ Phase of Care Start Date 3 (Data Item 39) OR Phase of Care End Date 3 (Data Item 40) ≠ Phase of Care Start Date 4 (Data Item 39) OR Phase of Care End Date 4 (Data Item 40) ≠ Phase of Care Start Date 5 (Data Item 39) OR Phase of Care End Date 5 (Data Item 40) ≠ Phase of Care Start Date 6 (Data Item 39) OR Phase of Care End Date 6 (Data Item 40) ≠ Phase of Care Start Date 7 (Data Item 39) OR Phase of Care End Date 7 (Data Item 40) ≠ Phase of Care Start Date 8 (Data Item 39) OR Phase of Care End Date 8 (Data Item 40) ≠ Phase of Care Start Date 9 (Data Item 39) OR Phase of Care End Date 10 (Data Item 40) ≠ Phase of Care Start Date 11 (Data Item 39) AND Phase of Care Start Dates 1 – 11 (Data Item 39) AND Phase of Care End Dates 1 – 11 (Data Item 40) AND Assessment Dates 1 – 11 (Data Item 42) AND Palliative Care Phase Types 1 – 11 (Data Item 42)

	AND RUG-ADL Assessment Scores 1 – 11 (Data Item 43 – 46) are not all blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5002

Edit Number	5003
Edit Name	Phase of care end date does not correspond with next phase of care start date
Effect	Critical
Care Type(s)	Palliative Care
Description	The Phase of Care End Date for one or more phases does not correspond with the next sequential Phase of Care Start Date. For example, the Phase of Care End Date for the first phase of care should be the same as the Phase of Care Start Date for the second phase of care.
Logic	IF Phase of Care End Date 1 (Data Item 40) ≠ Phase of Care Start Date 2 (Data Item 39) OR Phase of Care End Date 2 (Data Item 40) ≠ Phase of Care Start Date 3 (Data Item 39) OR Phase of Care End Date 3 (Data Item 40) ≠ Phase of Care Start Date 4 (Data Item 39) OR Phase of Care End Date 4 (Data Item 40) ≠ Phase of Care Start Date 5 (Data Item 39) OR Phase of Care End Date 5 (Data Item 40) ≠ Phase of Care Start Date 6 (Data Item 39) OR Phase of Care End Date 6 (Data Item 40) ≠ Phase of Care Start Date 7 (Data Item 39) OR Phase of Care End Date 7 (Data Item 40) ≠ Phase of Care Start Date 8 (Data Item 39) OR Phase of Care End Date 8 (Data Item 40) ≠ Phase of Care Start Date 9 (Data Item 39) OR Phase of Care End Date 10 (Data Item 40) ≠ Phase of Care Start Date 11 (Data Item 39) AND Phase of Care Start Dates 1 – 11 (Data Item 39) AND Phase of Care End Dates 1 – 11 (Data Item 40) AND Assessment Dates 1 – 11 (Data Item 42) AND Palliative Care Phase Types 1 – 11 (Data Item 42) AND RUG-ADL Assessment Scores 1 – 11 (Data Item 43 – 46) are not all blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5003

Edit Number	5004

Edit Name	Last phase of care end date is after separation date
Effect	Critical
Care Type(s)	Palliative Care
Description	The end date for the last phase of care is after the separation date.
Logic	The last Phase of Care End Date (Data Item 40) > Separation Date (Data Item 4) AND last Phase of Care End Date 1 – 11 (Data Item 39) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5004

Edit Number	5005
Edit Name	Last phase of care end date is before separation date
Effect	Critical
Care Type(s)	Palliative Care
Description	The end date for the last phase of care is before the separation date.
Logic	The last Phase of Care End Date (Data Item 40) < Separation Date (Data Item 4) AND last Phase of Care End Dates 1 – 11 (Data Item 39) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5005

Edit Number	5006
Edit Name	First phase of care start date is before admission date
Effect	Critical
Care Type(s)	Palliative Care
Description	The start date for the first phase of care is before the admission date
Logic	The first Phase of Care Start Date (Data Item 39) < Admission Date (Data Item 3) AND Phase of Care Start Dates 1(Data Item 39) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5006

Edit Number	5007
Edit Name	First phase of care start is after admission date
Effect	Critical
Care Type(s)	Palliative Care

Description	The start date for the first phase of care is after the admission date
Logic	The first Phase of Care Start Date (Data Item 39) > Admission Date (Data Item 3) AND Phase of Care Start Dates 1(Data Item 39) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5007

Edit Number	5008
Edit Name	Palliative phase of care is missing
Effect	Critical
Care Type(s)	Palliative Care
Description	The palliative care episode has palliative care dates or scores recorded but is missing the Palliative Care Phase Type.
Logic	IF Palliative Care Phase Type (Data Item 42) is blank AND Phase of Care Start Dates 1 – 11 (Data Item 39) AND Phase of Care End Dates 1 – 11 (Data Item 40) AND Assessment Dates 1 – 11 (Data Item 42) AND Palliative Care Phase Types 1 – 11 (Data Item 42) AND RUG-ADL Assessment Scores 1 – 11 (Data Item 43 – 46) are not all blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5008

Edit Number	5009
Edit Name	Palliative phase of care is invalid
Effect	Critical
Care Type(s)	Palliative Care
Description	One or more of the Palliative Phase of Care Types recorded is not a valid value. Refer to the relevant Data Definition for permitted values.
Logic	IF Palliative Care Phase Type (Data Item 42) ≠ 1, 2, 3, 4 or 9 AND Palliative Care Phase Type (Data Item 42) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5009

Edit Number	5010
Edit Name	RUG-ADL assessment date is before phase of care start date
Effect	Critical
Care Type(s)	Palliative Care

Description	The RUG-ADL Assessment Date for a given phase of care occurs prior to the Phase of Care Start Date. A Phase of Care Start Date must always be before the RUG-ADL Assessment Date.
Logic	IF RUG-ADL Assessment Date (Data Item 41) < corresponding Phase of Care Start Date (Data Item 39) AND RUG-ADL Assessment (Data Item 41) is not blank AND Phase of Care Start Date (Data Item 39) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5010

Edit Number	5011
Edit Name	RUG-ADL assessment date is after phase of care end date
Effect	Critical
Care Type(s)	Palliative Care
Description	The RUG-ADL Assessment Date for a given phase of care occurs after the Phase of Care End Date. A Phase of Care End Date must always be after the RUG-ADL Assessment Date.
Logic	IF RUG-ADL Assessment Date (Data Item 41) > corresponding Phase of Care End Date (Data Item 40) AND RUG-ADL Assessment (Data Item 41) is not blank AND Phase of Care End Date (Data Item 40) is not blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5011

Edit Number	5012
Edit Name	RUG-ADL assessment score(s) missing for palliative phase
Effect	Critical
Care Type(s)	Palliative Care
Description	The palliative care episode does not have any Phase of Care information recorded.
Logic	IF at least one RUG-ADL Assessment Scores 1 – 11 (Data Item 43 – 46) is blank AND Phase of Care Start Dates 1 – 11 (Data Item 39) AND Phase of Care End Dates 1 – 11 (Data Item 40) AND Assessment Dates 1 – 11 (Data Item 42) AND Palliative Care Phase Types 1 – 11 (Data Item 42) AND RUG-ADL Assessment Scores 1 – 11 (Data Item 43 – 46) are not all blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5012

Edit Number	5013
Edit Name	RUG-ADL assessment score(s) is not in range for palliative phase
Effect	Critical
Care Type(s)	Palliative Care
Description	The palliative care episode does not have any Phase of Care information recorded.
Logic	IF RUG-ADL Assessment Score(s) (Data Item 43 – 46) ≠ 1, 3, 4 or 5 OR RUG-ADL Assessment Score (Data Item 51) ≠ 1, 2 or 3 AND Assessment Dates 1 – 11 (Data Item 42) AND Palliative Care Phase Types 1 – 11 (Data Item 42) AND RUG-ADL Assessment Scores 1 – 11 (Data Item 43 – 46) are all blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5013

Edit Number	5014
Edit Name	RUG-ADL assessment date is missing for palliative phase
Effect	Critical
Care Type(s)	Palliative Care
Description	The palliative phase has some phase information recorded but the RUG-ADL Assessment Date is missing.
Logic	AND RUG-ADL Assessment Date (Data Item 42) is blank AND Phase of Care Start Dates 1 – 11 (Data Item 39) AND Phase of Care End Dates 1 – 11 (Data Item 40) AND Assessment Dates 1 – 11 (Data Item 42) AND Palliative Care Phase Types 1 – 11 (Data Item 42) AND RUG-ADL Assessment Scores 1 – 11 (Data Item 43 – 46) are not all blank AND Admission for Assessment Only ≠ 1 THEN trigger Edit 5014

Edit Number	5015
Edit Name	RUG-ADL phase assessment date is prior to admission date for palliative episode
Effect	Critical
Care Type(s)	Palliative Care
Description	The RUG-ADL Assessment Date is before the Admission Date.
Logic	IF RUG-ADL Palliative Phase Assessment Date 1 – 11 (Data Item 42) is >

	Admission Date (Data Item 3) AND RUG-ADL Assessment Date (Data Item 42) is not blank THEN trigger Edit 5015

Edit Number	5016
Edit Name	RUG-ADL phase assessment date is after the separation date for palliative episode
Effect	Critical
Care Type(s)	Palliative Care
Description	The RUG-ADL Assessment Date is after the Separation Date.
Logic	IF RUG-ADL Palliative Phase Assessment Date 1 – 11 (Data Item 42) is > Separation Date (Data Item 4) AND RUG-ADL Assessment Date (Data Item 6) is not blank THEN trigger Edit 5016

Edit Number	6000
Edit Name	Type of maintenance care is missing
Effect	Critical
Care Type(s)	Maintenance
Description	The maintenance episode is missing the Type of Maintenance Care.
Logic	IF Type of Maintenance Care (Data Item 47) is blank THEN trigger Edit 6000

Edit Number	6001
Edit Name	Type of maintenance care is invalid
Effect	Critical
Care Type(s)	Maintenance
Description	One or more of the Type of Maintenance values recorded is not a valid value. Refer to the relevant Data Definition for permitted values.
Logic	IF Type of Maintenance Care ≠ 1, 2, 3, 5 or 8 AND Type of Maintenance Care (Data Item 47) is not blank THEN trigger Edit 6001

Edit Number	9000
Edit Name	Assessment only answer is missing
Effect	Critical

Care Type(s)	Rehabilitation; GEM; Palliative
Description	The Assessment only answer is missing.
Logic	IF Admission for Assessment Only (Data Item 7) is blank THEN trigger Edit 9000

Edit Number	9001
Edit Name	Assessment only answer is invalid
Effect	Critical
Care Type(s)	Rehabilitation; GEM; Psychogeriatric; Palliative
Description	The Assessment only answer is not a valid value. Refer to the relevant Data Definition for permitted values.
Logic	IF Admission for Assessment Only (Data Item 7) ≠ 1, 2 or 9 AND Admission for Assessment Only (Data Item 7) is not blank THEN trigger Edit 9001

Edit Number	9002
Edit Name	Assessment only episode is longer than 3 days
Effect	Critical
Care Type(s)	Rehabilitation; GEM; Psychogeriatric; Palliative
Description	The subacute/non-acute episode indicates that the patient was admitted for more than three days however, the Admission for Assessment Only indicates that they were only assessed with no further subacute/non-acute intervention. Please correct or contact SANADC to verify.
Logic	IF Admission for Assessment Only (Data Item 7) = 1 AND Episode duration > 72 hours THEN trigger Edit 9002

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SECTION 10: REFERENCES

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